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FOUR CASES OF MYOMA OF THE UTERUS: THREE ASSOCIATED WITH SARCOMA AND ONE WITH AN UNUSUAL INTESTINAL COMPLICATION.

BY J. M. HUNDLEY, M.D.,

Clinical Professor of Diseases of Women, University of Maryland.

Two of the cases herein reported are of special interest in that one was under observation twelve and the other six years. These cases were seen a number of times by me, and a careful study made of the symptoms and ill-health in each case. My early training was obtained under very conservative influences, both in the treatment of uterine myomas and all gynecological diseases. I make this explanation because it would appear in the two cases specially referred to in this report that I was half-hearted in recommending operation, and that the operation of curettage which was advised was not sufficiently radical. It must be remembered that that advice was given a number of years ago. Twelve years ago the older gynecologists were using palliative means mostly. Where the hemorrhage was alarming and the tumor growing rapidly oöphorectomy was done. I have assisted at a number of such operations. I felt at that time that there was some better method of dealing with fibroids of the uterus, and began to visit other clinics. From the information obtained I began to change my viewpoint and became less conservative.

For the past two years when consulted by a patient with symptoms referable to the pelvic organs, and on examination I find a myoma, I advise operation unless there is some contraindication. In the 37 cases operated on at the University Hospital the past year myomectomy was done twice.

In the other cases (35) the ovaries were removed with the uterus.

Case I.—Mrs. P., aged 38, mother of two children, 15 and 11 years of age. I delivered her of her last child. At that time (1893) I did not discover anything abnormal with her pelvic organs. Four years later (1897) she consulted me for menorrhagia. On examination I found the uterus larger than normal and somewhat boggy, but did not detect a myoma. I advised curettage, which she declined. Ergotole was then ordered, and rest in bed at each menstrual period advised. I examined her one year later, when I found the uterus larger than at the previous examination. A diagnosis of uterine myoma was made and a curettage again advised and again declined. In the interval between the two examinations I saw her frequently. The menorrhagia became more and more pronounced. She left the city about the time of the last examination, and I did not examine her again until December, 1903, six years after the first examination. She now had a soft fluctuating tumor reaching two inches above the umbilicus, and was still having uterine hemorrhages. She was in bed two weeks of each month on account of the hemorrhage. She was very anemic, had a waxen skin and edema of lower limbs. She also had irregular heart action and shortness of breath on moving around, and pain in right inguinal region, which radiated down the leg. At this examination hysterectomy was urged and accepted. She was operated on December 22, 1903. A hysteromyomectomy was done. When amputating the uterus and separating the right broad ligament I noticed a cystic condition of the tissues which exuded a watery fluid. As she began to do badly, and being advised by the anesthetist to hurry, I completed the operation. After the operation the uterus was opened and found filled to the internal os with a softish tumor, which was diagnosed microscopically as sarcoma. Microscopically the tumor and the entire uterus proved to be a small, round and spindle-celled sarcoma. The tumor was a degenerated myoma. I informed the family of the facts in the case and the importance of removing the cervix. They refused any further operation. She left the hospital January

18, 1904. I examined her two days later and found a fluctuating mass in the right lateral vaginal fornix. As removal of the cervix was declined, and believing this cyst was likely a sarcomatous cyst, I began the use of Coley's erysipelas and prodigiosus toxins. Thirty-six injections were made in all. The cyst suppurated after the fourth injection. The toxins were injected into the cervix as well as into the cyst. The last injection was made June 7. I made a vaginal examination again October 15, 10 months after operation and four months after the last injection of the toxins, and the pelvic contents felt and appeared normal. At this time I urged removal of the cervix, but was refused on the ground that if I failed to remove all of the supposed sarcomatous cyst removal of the cervix would avail nothing. The outlook in this case is far from encouraging. A hysterectomy ought to have been done in 1898, when the myoma was first discovered.

Case II.—L. M., married, aged 45, no children. Menstruation always painful, but otherwise normal until 12 years ago. At that time (1892) the flow increased in amount and the pain in severity. It was at this time that I first saw her. She was then having irregular uterine hemorrhages, pain and general discomfort in her pelvis and painful and frequent micturition. A diagnosis of tumor of the womb had been made prior to my visit. On vaginal examination I found she had three interstitial uterine myomas. Curettage of the uterus was advised. She declined operation, and was subsequently treated by electricity. Electricity was being used at that time to arrest both the growth of the tumor and the hemorrhage. She says it did arrest the hemorrhage and reduced the size of the tumor. Seven years later I curetted her uterus for the arrest of hemorrhage. The uterus when I first saw her was in the pelvic cavity. At this time it was three inches above the pubis. The uterus was certainly larger at this time, and I doubt if the electricity had had any effect upon it whatever. I saw and heard from this case frequently from this time (1899) to November, 1904. During all of this time she was never well and was being treated in one way and another. She consulted me again last November. The tumor was now a little above the umbilicus. At this time the menstrual periods were not very profuse or prolonged, but painful. The most distressing symptoms were nervousness, flatulency, weight of the tumor and irritability of bladder. Hysterectomy was now urged, and the operation was done November 30, 1904. On opening the abdomen the uterus was found to be soft and fluctuant in two areas near the fundus. These areas were very red and angry-looking. From this appearance I suspected some degenerative change in the myomas, and consequently did a pan-hystero-myomectomy.

Pathologist's Report. — Sections from seven different points of myomas and uterine body-wall show great vascularity and widespread areas of spindle-celled sarcoma. Sections from cervix of uterus show no evidence of malignancy.

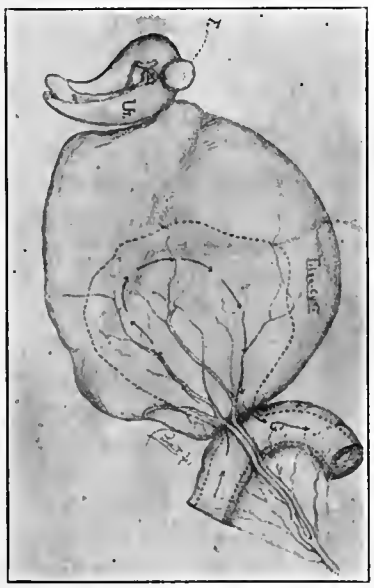
Convalescence was uneventful, and the patient left the hospital December 28.

Case III.—Mrs. G., admitted to the University Hospital June 29, 1904, with the following history: Married, aged 48; has had six children—five living, one dead. Her menstrual history was normal up to two years ago, and she was healthy and strong up to that time. At that time she began to have irregular uterine hemorrhages. In June, 1902, she had beside the uterine hemorrhage a severe attack of abdominal pain which confined her to bed for a month. She has never recovered from the effects of that illness. Continuance of hemorrhage and pain caused her to come to the hospital. The lump she discovered in her right lower abdomen in 1902 has steadily increased in size. Previous to operation a diagnosis was made of uterine myoma with double pus-tubes, which was confirmed at operation. A pan-hystero-myomectomy was done July 2, 1904. Her myoma proved to be a mixed small, round and spindle-celled sarcoma.

She left the hospital well July 22.

Case IV.—M. E. C., single, aged 39; has always been delicate, but never had any serious illness until July, 1900. Her menstrual periods have always been painful and profuse. In 1900 she began to have irregular uterine hemorrhages. After one of these attacks of uterine hemorrhage in July of that year she had a sinking spell, and began from that time to lose ground. She grew weaker and lost flesh. In March, 1903, she fell down the steps at home, and the injuries sustained confined her to bed for seven weeks. While in bed she passed a number of bloody stools, and had fever and chills, and suffered with abdominal pains. When I saw her (December 5, 1904) she had the appearance of one suffering from a malignant disease. She was emaciated and very feeble. Since March, 1903, her menstrual periods have been normal in amount and duration. A diagnosis of tumor of the womb had been made in

February, 1902, and again in 1904, but was told she need not worry about it, as it would disappear in time. On abdominal palpation a mass could be felt occupying the pelvis. A vaginal examination revealed a mass filling the pelvic cavity, and on top of this mass a small uterus could be made out. She was very sensitive to pressure and the examination was not entirely satisfactory. The mass appeared at that time to be inflammatory. I advised operation, which was accepted. She was operated on December 12. I expected to drain a pelvic abscess through the posterior vaginal fornix. Examination under anesthesia caused me to change my diagnosis to a growth of some kind rather than that of a pelvic abscess. On opening the abdomen a tumor was found filling the pelvis. It was adherent everywhere, but not attached to the uterus. A small necrotic pedicle on the posterior wall of the body of the uterus showed the origin of the tumor. The tumor had lost its attachment to the uterus and had become parasitic. Its blood supply was now derived from a portion of the ileum. The blood-vessels given off from the ileum to the tumor were as large as the radial artery. The accompanying drawing, made by Dr. Brent, gives a good idea of the tumor and the attached portion of bowel. On freeing the intestine from the tumor it was found that the lumen of the intestine



communicated with a cavity in the tumor. The cavity of the tumor contained grapeseed and fecal matter. About five inches of bowel was resected and an end-to-end anastomosis made with the Murphy button. The right tube and ovary were removed, and also a small subperitoneal myoma from the fundus of the uterus. The patient was greatly shocked by the operation and died three days later. After death an examination was made of the site of the intestinal anastomosis and it was found intact. There was no peritonitis or evidences of infection.

Pathologist's Report.—The parasitic fibro-cyst is 12 cm. in diameter, with a cavity 10 cm. in diameter. The cavity of the cyst communicates with the lumen of the gut at the point of attachment by an opening about 2 cm. in diameter. The wall of the cavity is soft and ulcerating. The growth receives a rich blood supply from the intestine. The cyst contained a quantity of grape-seed and other food remains. Microscopically, sections from numerous areas of the cyst wall show the tissue to be that of a rather dense fibromyoma which is very vascular, highly inflamed and about to ulcerate. No evidence of sarcomatous change is found. The intestinal wall where the growth was attached shows marked vascularity and inflammation, but no sarcomatous change.

This series of cases emphasizes the importance of early operation in uterine myomas. The life of the last case would in all probability have been saved had she been operated on earlier. I think the bloody stools which occurred in March, 1903, can be explained by the lesion found in the bowel and the condition of the inflamed and ulcerating myoma. While the knowledge that uterine myomas undergo malignant degeneration is not new, I do not think the possibility that such a degeneration might occur in any case and without in any way manifesting its occurrence until late in the disease was fully appreciated until comparatively recently. Complications other than malignancy are met with in a large proportion of the cases brought to operation and materially enhance the dangers of the operation. In looking back over my past experience and taking into account the invalidism and suffering which myomas entail, and then having in mind the possibility of the occurrence at any time of malignant degeneration and other more or less serious complications, I believe it is wise to remove all myomas giving rise to symptoms unless there exists some well-founded contraindication. When we take into account that the mortality should not exceed 2 per cent. in uncomplicated hysteromyomectomies, I do not think my position is radical, but conservative.

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STATISTICAL REPORT OF THE APPENDICAL WORK DONE IN THE UNIVERSITY HOSPITAL DURING THE YEAR 1904.

By A. B. Lennan, M.D.,
Assistant Resident Surgeon.

At the request of Prof. Randolph Winslow, senior surgeon to the hospital, I beg to present the following report of the appendical work done at the University Hospital for the year 1904.

In making up the statistics of the appendix work done in this hospital in the past year there has been no attempt to include those appendices removed during operations for other abdominal troubles. This is a record of primary operations for appendicitis entirely.

It comprises 80 cases, of which 72 recovered and eight died. Of the eight deaths, seven were due to general peritonitis; one case was due to sepsis. In this case the boy had an acute suppurative gangrenous appendicitis, with considerable serous fluid in peritoneal cavity and considerable local peritonitis. The appendix was removed, a small drain inserted and abdomen partially closed with interrupted sutures. Patient did well for first two days; then gradually grew worse, dying on the fifth day, with very little temperature, but rapid pulse.

Of the 80 cases there were 22 cases of acute catarrhal appendicitis, with a history of from two to 14 days' duration, all of which were operated upon and cured and discharged within three weeks.

In two of these cases there was a localized serious peritonitis, and both were drained with a small gauze wick down to the seat of trouble. The drains were removed on the third day and the wounds allowed to heal. These cases also recovered without any complications.

There were 16 cases of acute suppurative appendicitis with abscess.

In all of these cases the appendix was removed and abscess cavity drained with gauze. All recovered except one case. In this case the patient did well for two weeks, then developed intestinal obstruction, which required a second operation. She was opened in median line, and a great many adhesions found, tying up the intestines, but it was impossible to say which caused the obstruction. All of the adhesions were carefully separated and abdomen closed with drainage. The patient was put to bed very much shocked, but she soon rallied and went on to recovery.

This case was reported by Dr. Wright at the last meeting of our medical society.

In the above number probably belong the four cases of acute gangrenous perforative appendicitis with post-cecal abscess.

In two of these cases the incision was made in the back instead of in the usual way, going down behind the peritoneum, letting out the pus and draining the abscess cavities. In both cases the appendix was found and pulled off, but no attempt was made to suture over the appendix stump. A fecal fistula developed, which closed spontaneously in about one week.

The other two cases were operated on in the usual way, the appendices removed and abscess cavity drained. All four cases recovered.

In this class also belongs an interesting case of acute suppurative perforative appendicitis, with abscess which extended to the under surface of the liver. There were multiple liver abscesses due to colon bacilli. The appendix was removed and the abscess cavity, as well as the abscess of liver, drained with gauze and a rubber tube. This patient did well for several days, then became suddenly worse and drained large quantities of colon pus through a bronchus in left lung. The pus was expectorated, and the odor was so foul that the patient had to be isolated.

Ultimately he made a good recovery.

There were 21 cases of chronic appendicitis with a history of from two to four attacks. In all of these cases the appendix was removed. There was no suppuration in 20 of these cases, and abdomen was closed without drainage. In one case there was present a localized abscess, which was the result of the last attack, and this was drained. All of these cases recovered. In dealing with these clean cases in which the abdomen is closed without drainage and the patient is doing well, there is a growing tendency among the operators at this hospital to get their patients up sooner than was formerly done. In several instances the patient was gotten in a rolling chair as early as the fourth day and discharged at the end of the second week. In this series of cases there were five cases of fecal fistula following operation for appendicitis. In four of these cases no secondary operation was necessary to close the leak in the cecum. Spontaneous cure occurred in from one to eight weeks. In one case the hole in the cecum was too large for spontaneous closure, and this patient was operated on and the hole in gut sutured after a partial loosening up of cecum. A cure resulted.

Among these cases are three of recurrent appendicitis without suppuration who refused operation. The symptoms abated and the patients left the hospital.

There were 13 cases of general peritonitis, with six recoveries and seven deaths. In six of these cases the abdomen was thoroughly washed with large quantities of hot normal salt solution, three of which recovered, three died.

Three were opened in two places, and two recovered and one died. In one of these two a third opening was made just under the lower border of liver several days after primary operation. All cases of general peritonitis which resulted fatally died within five days after operation. In two of these fatal cases the temperature did not go above 101° F., but in all there was a rapid pulse-rate.

In one of these cases the patient was apparently getting much better for two days; pulse improved, temperature came down, abdomen less tense and bowels moved twice. He then began to do badly; while his temperature did not go very high, his pulse became more rapid and weak. He died on the fourth day. At autopsy there was found to be no improvement in the local condition; the abdomen was full of thick pus and the intestines gangrenous in various places. Just why this apparent improvement took place is an interesting point. While our mortality in this series of cases seems high, we should remember that there was only one death in which peritonitis did not already exist to a marked extent before the operation.

DISINFECTANTS AND ANTISEPTICS—SYNOPSIS OF A LECTURE DELIVERED TO THE NURSES OF THE UNIVERSITY HOSPITAL FEBRUARY 2, 1905.

By Joseph T. Smith, M.D.,
Associate in Hygiene.

This evening it is my purpose to direct your attention to the subject of disinfectants and antiseptics, but before doing so it is necessary that you should have a clear understanding of the meaning of certain words, and I trust you will fix the definitions in your minds and always use the words correctly.

1. What do we mean by infection? The word is derived from the Latin and means to place in or into. An infectious disease is, therefore, one whose causative agent has been placed in the tissues of the body. Malarial fever is an infectious disease, for its causative agent has been placed in the body in this case by a mosquito.

2. What do we mean by contagion? This is simply a word used to describe one of the modes of infection. A contagious disease is one that is transmitted by direct or indirect contact with an individual who is infected; thus, smallpox is a disease of this character, because indirect contact is sufficient to enable the causative agent to gain access to the body.

3. What is meant by a disinfectant? We had best define it as an agent which is capable of destroying the cause of an infectious disease. It is not well to confine the destruction to micro-organisms, for we are not sure that all infectious diseases are so caused; thus, in the use of a disinfectant for diphtheria we do not attempt to destroy the micro-organism, but the toxines which it produces.

4. What do you understand by an antiseptic? It is an agent which prevents the cause of an infectious disease from acting or greatly diminishes its virulence without destroying it. Cold is a restrainer, not a destroyer. Iodoform, probably by slowly liberating iodine when in contact with living tissues, markedly diminishes the activity of many disease agencies.

5. A deodorant is an agent which destroys odors without any reference to infection.

We may for convenience group all disinfectants into four classes: First, the mechanical, as when water is passed through a sand filter and disease-dealing organisms are kept back, or as in thoroughly scrubbing the hands; second, the physiological, as the diphtheria antitoxine, where a something is produced by the physiological functions of the body which is capable of destroying the toxine of diphtheria; third, the thermal, as in the use of any form of heat; fourth, the chemical, the word being self-explanatory.

We will note but two of these at this time—the thermal and the chemical.

Heat, when it can be used in the form of fire, is the best disinfectant, and, wherever possible, infected materials should be destroyed by fire. A very excellent use can be made of fire in the sickroom by going around the room thoroughly with a blazing torch of paper or a pan of live coals. Not only is the atmosphere thus burned free from infectious agents, but strong air currents are set up, inducing ventilation. I would strongly recommend this to you.

Hot dry air (300° F.) is not a satisfactory method of applying heat. It renders fabrics

brittle, has but little penetrating power and takes a long time to do its work.

Boiling substances in water containing 2 per cent. of washing soda for 15 minutes will result in the killing of all known disease germs; some spores may escape, but they are mostly harmless. It is, of course, necessary that the water penetrate all of the material to be disinfected.

Steam is the most satisfactory disinfectant. It may be used as live steam, 212° F. The Arnold steam sterilizer is very popular for the utilization of steam in this way. Evidence goes to show that few, if any, pathogenic organisms can withstand such heat if properly applied for a sufficient length of time—three-quarters of an hour. Here, as in the case of boiling water, the material to be disinfected must be penetrated by the steam, hence time is a very important element. Where surface disinfection only is required, as with instruments, much less time is requisite than in the case of woven fabrics.

Steam under pressure (240° F.), if introduced into a vacuum chamber or one thoroughly heated, so that a minimum of condensation shall take place, is the most valuable and efficient of the disinfectants except fire. It will kill all known forms of pathogenic organisms and the most resistant spores in a few minutes, and it possesses great penetrating power. Woven fabrics, if not too thick, have their meshes penetrated, so that bedding, etc., can be disinfected in this way.

When we turn to the list of chemical disinfectants and antiseptics we find them legion. I will, therefore, select but a few of the most efficient, and you will be wise to hold to their use.

Carbolic acid has no doubt at once come into your minds, and rightly, though it has its limitations. In a 2 or 3 per cent. solution we have an efficient antiseptic, and a 5 per cent. or saturated solution is an efficient disinfectant. In either case the acid solution must be thoroughly mixed, and in excess with the material to be disinfected, as in coagulating albumen it is rendered inactive. Difficulty is experienced here in knowing how much to use in any given case and to be sure it comes in contact with all the material. The acid does not mix well with cold water; warm water should therefore be used, and then only a 5 per cent. solution can be made, unless glycerine is added. The odor of the acid is very objectionable to many. It is very poisonous, and as it causes anesthesia of the skin, it cannot be used for instruments unless it is all removed before they are handled; nor for the hands where delicate work is to be done, as it dulls the sense of touch. The use of carbolic sprays in rooms and the placing of plates containing carbolic solutions are not to be relied upon.

Lime in its two forms of the so-called chloride (commercial name) and milk is a most valuable agent for disinfectant purposes. The chloride should be purchased only in tin boxes securely sealed; that sold in open packages is unreliable. To be efficient it should contain 35 per cent. of available chlorine. It is freely soluble in water; yields up its chlorine readily upon contact with organic matter. It is comparatively cheap and is not poisonous. I would urge it upon your attention as one of our best agents for ordinary household uses, such as the disinfection, or, in weak solutions, for antiseptic purposes, of water-closets, sinks, etc. Milk of lime, made with lime and water in the proportion of one to four, is the best agent we possess for disinfecting the typhoid stools. It should be thoroughly mixed with the material to be disinfected and in excess; that is, until the mass is alkaline to litmus, and allowed to stand for two hours. It may also be used for sinks, etc., as an antiseptic.

Formaldehyde gas is made by passing the vapor of methyl or wood alcohol over red-hot metal or carbon; that is, by the oxidation of methyl alcohol. It is most valuable as an antiseptic, and is found in the market in two forms—formalin, which is a 40 per cent. solution of the gas in water, and paraform, which is compressed into tablets. When more than 40 per cent. of the gas is added to water a white precipitate is thrown down which we know as paraform. Heat will set free the gas from either of these forms, and with the special lamps made for the purpose it is readily managed. The gas has very limited penetrating powers, but acts very quickly as a surface disinfectant. It is non-poisonous, but it is very irritating to mucous membranes. It is very diffusible, hence all the cracks and crevices in a room should be sealed up before the gas is introduced. It renders "connective tissue and all gelatinous substances insoluble in either hot or cold water, and it is probably to this that its germicidal activity is largely due, since the food supply of the bacteria, if not the substance of the latter themselves, is partly of this nature." It hardens and roughens the skin of the hands, and so cannot be used upon them. We have here an agent of great value for the disinfection of instruments and of rooms which have been stripped of

carpets and other woven fabrics; in other words, where surface disinfection is called for.

Bichloride of mercury does not hold the high place in our regard it once did. While efficient in weak solutions (1 to 500, 1 to 2000), it is very poisonous. It is rendered inactive by uniting with albumen, and hence must be used in excess, and it corrodes instruments. It is now chiefly used for skin disinfection, as the hands of the surgeon or skin at the seat of an operation.

We possess a number of agents which owe their value as disinfectants to the fact that they readily yield up their oxygen, of which the peroxide of hydrogen and permanganate of potash are examples. The former is used in a 15-volume solution and is very active. All the material must be brought into direct contact with it. The latter stains badly in a saturated solution (1 to 16). It is used upon the hands after they have been thoroughly scrubbed, and the stain removed by a solution of oxalic acid.

Of the antiseptic agents, possibly boric acid and the compounds of iodine are most extensively used. Boric acid is a mild antiseptic, but being less irritating than most other agents of its class, is of value where a mild action is desired. It may be used in powder or in solutions of any desired strength. Iodine furnishes us with many compounds — iodoform, aristol, europhen, etc. Iodoform is the one most extensively used on account of its cheapness, but aristol has much less odor. All of these act probably by being decomposed when in contact with living tissues and yielding up iodine. Iodoform has given rise to toxic symptoms such as lassitude, hallucinations, and even convulsions. These preparations are used as dusting powders, or, as is the case with boric acid, are forced into the meshes of gauze, and we have borated gauze, iodoform gauze, etc.

The camphors (camphor, menthol and thymol) are mildly antiseptic, thymol being probably the most active of the group. Being gums, they are but slightly soluble in water; freely so in alcohol.

Sulphur dioxide, as produced by burning sulphur in rooms in the form of candles or otherwise, is not as efficacious as formaldehyde, and should not be substituted for it. This gas is inactive in a dry atmosphere, and is or should be used only for ships, cellars or places infested with rats or vermin.

You will note that in all that has been said no one of the agents mentioned is good for all purposes and in any case. It is necessary to select the agent suited to the indications called for by each case. It is well, therefore, in every case of infection to study carefully the indications and adapt the agent to them. Do not use these and other agents about which you know nothing in a haphazard way, but remember good can only be accomplished by a thoughtful adaptation of means to an end.

A UTERINE DILATOR FOR CASES OF ABORTION OR ECLAMPSIA WITH A RIGID OR ELONGATED CERVICAL CANAL.

By T. A. Ashby, M.D.,
Professor of Diseases of Women in the University of Maryland, etc.

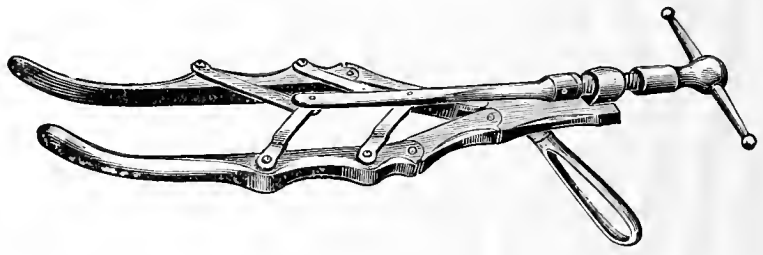
Some 10 years ago I was called to attend a case of abortion of some three days' standing before I saw the patient. The woman had lost a large quantity of blood and had had violent expulsive pains without expelling anything but blood-clots. The fetus and afterbirth were bottled up in the uterine cavity, and the canal of the cervix was as rigid and unyielding as if labor pains had not been acting on it. Upon examination I found the cervix elongated and the canal so contracted that it was impossible to introduce the finger into the uterine cavity. I tried with every method and instrument at my command to dilate the canal, but only succeeded after an hour's hard work in overcoming the rigidity to an extent that admitted the blades of a strong clamp forceps. With this instrument I removed the fetus in sections and finally cleaned out the uterine cavity. With this experience I decided to have an instrument constructed that would meet the conditions presented by this class of cases.

I consulted Mr. Charles Willms, at that time at the head of the Charles Willms Surgical Instrument Co. of this city, and with his assistance had a dilator made which has rendered me most valuable service since in a number of cases of rigid cervix where rapid dilation was required to empty the uterus in cases of abortion and of eclampsia. The instrument has great power and a large dilating expansion. It will easily expand the canal of the cervix to the diameter of three inches if that amount of dilation is required. In cases of eclampsia, where immediate dilation of the os is called for to bring on delivery, the instrument has been of special service to me.

Three weeks ago a case of this character came

under my observation which will illustrate the value of the instrument. A primipara 23 years of age was seized with eclampsia at 6 o'clock in the morning. Convulsion after convulsion followed rapidly, and the patient soon became comatose. Her family physician reached her bedside at 8.30 o'clock and at once attempted to bring on labor. He worked for one hour trying with his hand to dilate the cervix. There were no labor pains to assist him, and his efforts were unsuccessful. I saw the case at 9.30 o'clock, and as soon as preparation could be made the patient was lifted onto a table and prepared for immediate delivery. I found the cervix only dilated sufficiently to admit two fingers, and extremely rigid. With the dilator here referred to the os was dilated in a few minutes to the size that readily admitted both blades of the Tarnier forceps, which were applied to the child's head above the brim of the pelvis. With traction the child, about seven months' utero-gestation, was delivered moribund. The patient had several convulsions whilst on the table, but none subsequent to delivery, though she remained comatose for over 24 hours. She has since entirely recovered. The child perished early in the attack of convulsions, but it is possible that it might have been saved had delivery followed the first efforts at delivery when reliance was placed in the hand as a dilating force.

If we profit by experience in clinical work we must recognize the value of being prepared for emergency cases. In an experience of 10 years' work since this dilator was made for me I have had occasion to use it less than one dozen times. Yet when it has been called into service it has possessed a value that was not only time-saving, but life-saving. I would not practice my profession without it or some equally good substitute, and I know of no substitute. Everyone who has used the soft-rubber dilator must know how unreliable it is at the time most wanted. The smaller dilators of the Goodell pattern are of little service in this class of cases. They have neither the power nor the expansion to meet the indications found in cases of excessive rigidity and requiring the removal of large bodies from the uterine cavity. The hand is not only a dangerous, but a poor instrument for rapid dilation of the cervix. Its value is limited to cases in which the cervix is easily distended. We can never be sure that it may not carry infection. Incision of the cervix with scissors or knife may have its advocates, but why cut when divulsion can be made to accomplish the end sought? The dilator to which I now call attention can be taken apart and sterilized in a short time. It is always ready



for use and can be relied on in critical moments. It may seldom be needed, but when called into use its value is unmistakable. As the chain is no stronger than its weakest link, so the man who is best equipped for emergencies is to that extent best able to deal with trying and difficult experiences.

A notice of this dilator has been published in my work on "Diseases of Women," but so far as I know has not been noticed in any other publication. As the first edition of my book was burned in the fire which destroyed the business section of Baltimore one year ago, I have no hesitancy in again calling attention to this dilator.

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THE DISPENSARY.

By Gordon Wilson, M.D.,
Chief of Clinic, Practice of Medicine, University of Maryland.

Within the past few years many changes have taken place in this department in its physical characteristics as well as in the method of treating the patients and instructing the students.

With the completion of the laboratory building this past autumn, and a consequent removal of the pathological laboratory from the ground floor of the hospital to its own building, there was undertaken a remodeling of the rooms on the basement floor and a change in the assignment of the rooms to the different departments

that go to make up the out-patient service. The old gynecological room is now connected by a door with the large surgical room and is used for treating women and children suffering with minor surgical maladies, and in addition the surgeons have the use of the nose-and-throat room as a place for the physical examination of surgical cases. The department of diseases of children has been moved to the old neurological room, and their old room is now used for the treatment of cases coming under the head of diseases of the stomach and intestines. The old pathological laboratory has been divided into two rooms—one large one for the gynecological service, while the smaller one is used as a room for cystoscopic examinations in conjunction with the genito-urinary clinic, which has its large room, for history-taking, irrigations, etc., just to the west of it and connected with it by a door. The neurological clinic is now located in a room at the end of the corridor, which in the past was not used for dispensary purposes. The clinics for the treatment of diseases of the nose and throat, eye and ear and skin retain their old rooms. The medical clinic uses its old room simply for history-taking, and has been given a new room opposite the doctors' dining-room for the physical examination of male patients, while the room which is used in the afternoon for diseases of the skin is in the morning used as a place for the physical examination of female medical patients. In addition to the above, improvements have been made in the methods of heating the dispensary, and changes made in minor laboratory facilities.

The pharmacy has now been put in charge of a paid graduate pharmacist, and the old stock prescriptions have been revised by a committee composed of the chiefs of clinics, which has resulted in the throwing out of many old prescriptions and their replacement by a larger number of newer and less complex ones, which has caused a saving of time in the dispensing of drugs and a more exact means of estimating the therapeutic value of a medicine in the treatment of a given case.

At the beginning of the present scholastic year a decided improvement was made in the value of the dispensary service to the patients by the assigning of a member of the graduating class to the dispensary, whose sole duty was the examination of sputa and also of the blood of any patient for whom it seemed desirable as an aid to a more exact diagnosis.

Another change that had its start with the present session of the medical school was the method of instructing the sections in physical diagnosis, which is now done in a large, well-lighted room situated next to the officers' dining-room, and the cases for demonstration and study are drawn from the dispensary patients and at times from the ambulatory hospital cases. As an aid to the getting of dispensary patients to attend the clinic at a *definite* time there has been put in force in the medical dispensary a card-index of the patients, indexed by diagnoses, and postal cards have been printed in blank asking a patient to return to the dispensary on a blank day at a blank hour, with the following postscript: "*If you come on time your carfare* (10 *cents*) *will be given you.*" It is hoped that by this means an ample supply of material for teaching purposes will be secured.

The growth of the service is well shown by the fact that during the years 1903 and 1904 2600 *new* histories were written in the medical clinic, while for the two years ending December 31, 1902, there were only 1163. This increase is due not simply to a larger number of patients, but also to the fact that formerly only two physicians were in attendance on this clinic, while now there are six. This improvement is not by any means confined to the medical clinic, but is conspicuous in all.

The number of patients applying for treatment during the year 1904 at the dispensary was 24,746, which means not only an immense amount of suffering relieved, but also a wealth of material for the advancement of the study of medicine both in its graduate as well as its undergraduate aspect.

In future numbers of the BULLETIN the advances in each dispensary service will be considered separately and more fully.

The University Hospital Bureau is in charge of a Committee of the Medical Staff.

Alumni of the Medical School and physicians visiting Baltimore are cordially invited to register their names and addresses by telephone or in person while in town, so that cards showing the daily operative and clinical work of the various departments can be mailed them extending an invitation to be present.

Visiting physicians will be welcomed, and any information in the sphere of the Bureau will be gladly given.

THE HOSPITAL BULLETIN

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EDITORIAL

To the Alumni of the University of Maryland:

In presenting this first number of the HOSPITAL BULLETIN to the alumni and friends of the University of Maryland its promoters offer no apologies for entering a new field of journalism. The growth of the work of the University in laboratory, didactic and clinical teaching, the rapidly-increasing size of its student and teaching bodies, the yearly additions to its alumni and friends all make it necessary that there should be placed on record the progress of this work, and an exchange of pleasant relations between the alumni, now widely scattered, and the present teaching body. Those of the alumni who have not visited the University within the past 10 years can form no definite idea of the growth of the institutions connected with the University within that time. The student and teaching bodies have doubled within that period. The new hospital building has been erected, new laboratories have been built and equipped, and in every department of work a new order has been arranged.

This expansion has gone on so gradually as to seem to those in present charge to be slow, but it has been reached by persistent effort and with a determined zeal to bring the work of the University up to the highest requirements of a modern education. In the field of clinical teaching the University is aiming to keep in the front rank with other medical schools. One of the most important functions of the BULLETIN will be to place this clinical work on record and to encourage the hospital staff to place before the profession the large amount of valuable clinical material which has been allowed to go to waste for the want of such a medium of publication as the BULLETIN will present. As a stimulus to a more careful study of disease in the hospital and dispensary, and to literary effort, it is believed this publication will have a value to the teaching body. It is also believed that this method of instruction will prove of interest and value to the friends and alumni of the University who may receive the monthly visits of the BULLETIN. In addition to the clinical material which will be published from month to month, it is proposed to publish notes and items of a personal character and to keep the alumni of the University in touch with their alma mater and with their classmates. The busy man in a far-distant State or country may in this way learn of the fortunes of an old classmate of years long gone by. Memories of student life may in this manner be recalled and old friendships may be revived. We ask the graduates of the University to co-operate with us in making this feature of the BULLETIN one of live interest to all of its readers. We ask for notices of deaths, marriages, appointments, for personal reminiscences of student days, for reports of cases and for original papers which would interest or instruct our many readers. Complimentary copies will be sent from time to time to every alumnus whose address can be found. To those who wish to receive the regular monthly visits a nominal subscription price will be charged.

With our purposes thus defined we enter upon a work which we trust will redound to the advantage of its readers.

In presenting the BULLETIN to its readers in its present humble and unassuming character we shall feel no shame or timidity by reason of its comparison with the larger and more imposing hospital publications issued by institutions endowed with wealth and supported by the highest learning and talent. If there is a place in this great country for medicals schools such as gave the M.D. degree to our fathers and grandfathers and to many of the ablest men who have taught and practiced medicine in America, there must still be room for the unendowed school and hospital. As much as we value original work and the highest training in scientific medicine, the clinical school has a place in our educational system. As long as men must be trained for the practice of medicine in rural districts and in crowded sections of our cities, where men of exceptional talent and high education cannot and will not live, the physician trained in clinical work will occupy a useful position. It is to this

large and useful class that the BULLETIN hopes to be most helpful. If it does nothing better than to stimulate the hospital staff to observe and record the great mass of clinical material found in the University Hospital and to enforce a better system of keeping the hospital records, its existence will not be in vain. It is believed, however, that its functions will reach beyond the walls of the institution it attempts to represent. With ample material in the hospital wards and dispensary to instruct the student body, there is no reason why this material should not be given to the profession at large. The issues of the BULLETIN will determine whether this position is well taken.

We believe the time is not far distant when the entire fourth-year class will be required by the leading medical schools of this country to reside in the hospitals connected with these schools during the last year of study. The number of internes now connected with the University of Maryland has doubled within the past 10 or 12 years, and represents over 30 per cent. of the graduating class. Provision will be made next year for the further increase in this number. The idea that the interne body is overcrowded is a mistake. There is ample room to instruct the entire graduating class if the clinical material is properly assigned and utilized in class instruction. One case thoroughly well studied can be made to instruct a dozen men better than a dozen cases assigned to one man and poorly utilized. What is most needed in the system of instruction is thoroughness of study of the material allowed to go to waste. The student must be brought to consider himself an apprentice. He should not be allowed to shirk duty or to go through his work in a slipshod way. He should be examined at the end of the course on the clinical work, and it should be graded on equal terms with his didactic course.

In Dr. Osler's farewell address at the Commemoration Day exercises on February 22, according to the *News,* he used the following language: "Personally, there is nothing in my life in which I take greater pride than in my connection with the organization of the medical clinic of the Johns Hopkins Hospital and with the introduction of the old-fashioned methods of practical instruction. I desire no other epitaph—no hurry about it, I may say—than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important work I have been called upon to do."

No one can question the preponderating value of ward instruction in hospitals, and Dr. Osler may well feel that that was the most important work which he did in the way of medical education. But we were not aware that it was such a new thing, or that it was only introduced since the establishment of the Johns Hopkins Hospital. Certainly we have had it in the University Hospital for many years—there can be no doubt ever since the hospital was erected in 1823. Who has not heard of the Emperor making his rounds of the early morning by candle-light, or of those master clinicians whose memory should ever be green in our midst—Power and Frick, and of the elder Chew? The writer can recall the daily ward service of Richard McSherry, Christopher Johnston, Samuel C. Chew, Frank Donaldson, William T. Howard and Julian J. Chisholm. But doubtless Dr. Osler has much improved the service by better regulations, stricter requirements and full and accurate records by the students. Thus his work has been a valuable one and may well serve as a model and inspiration for others. We doubt if any institution can show a better and more reliable collection of clinical records than the Johns Hopkins Hospital.

The University Hospital is the most important and considerable appendage to the University. Beginning 82 years ago in a very modest way with four small wards, it has grown and grown until now it is one of the largest and best-appointed college hospitals in the country. In the last catalogue we find the names of 82 persons connected with it in a medical capacity. The total number of patients treated in the year ending April 15, 1904, was 2111, of whom 1295 were public patients. There was an average of 68 operations per month; there were 816 major operations; number of cases treated in the accident department, 1206; number in the dispensary, 24,746; number in the maternity department, 500, and 42 autopsies. The building for the accommodation of the 30 resident students immediately adjoins the hospital on the west. The maternity department is just across the street, and furnishes an abundance of clinical material, each graduate last year having seen 15 cases of labor. The out-patient service in both departments is well organized and working efficiently. There is an excellent Training School for Nurses attached to the hospital, with 55 students and a three-year course.

There is also a post-mortem building and excellent *x*-ray apparatus. In addition to the hospital proper, the clinical facilities of the Presbyterian Eye, Ear and Throat Charity Hospital, the Hospital for the Relief of Crippled and Deformed Children and Bayview Hospital are at the service of students and teachers.

It is all this vast material of which the BULLETIN aims to be the mouthpiece. Is it unreasonable to think that it should have expression, or to suppose that the interest of our clinicians can be aroused to co-operate with us in its publication?

ABSTRACTS AND EXTRACTS

Dr. L. M. Allen, of this city, has in the February number of the *American Journal of Obstetrics* a paper on "Eclampsia," from which the following abstract has been made:

The article is based upon the observation and treatment of 43 cases, 33 active and 10 "severe toxemias."

These cases occurred in the last 3400 confinements in the Lying-In Hospital of the University of Maryland. The majority of the cases occurred during pregnancy, rather than during labor or the puerperium.

In all of the cases premonitory symptoms were present, a point emphasized by the author in the statement that these symptoms are rarely absent and can be recognized in the majority of instances early enough to prevent the convulsions and save the patient, concluding that eclampsia in most instances is a preventable disease. The pathology is dealt with at some length and is based upon the findings in three maternal and two infant autopsies, and confirms the observations of Schmorl, Jurgens, Klebs, Lubarsch, etc.

The results of urinary examinations thoroughly demonstrate that there is no direct relation between the kidneys and eclampsia as cause and effect. These organs are usually the seat of disease (acute parenchymatous nephritis) at the time of the attack, but the disease is the result of the eclampsia toxine rather than the cause.

The various causes of the disease are discussed at length, and while no definite conclusion is reached, the author expresses the opinion that the toxine is of maternal rather than fetal origin.

As substantiating this theory several cases are cited—one (the author's) in which the convulsions occurred seven days following the death of the fetus in utero; another reported by Hitchmon from Schouta's clinic, where eclampsia occurred in a case of hydatid mole three weeks after the disappearance of the fetus. Added to these is the fact that the pathological changes are much more recent in the fetal than in the maternal organs. In regard to the prognosis, the author concludes that it is impossible to say what will happen in a given case, but believes the mortality should be kept below 20 per cent. The mortality in the above series was 11.5 per cent.

Treatment.—Treat premonitory symptoms by diet, elimination and sedatives if necessary. If in spite of this the symptoms get worse, empty the uterus.

When seen during an active attack give sedative (morphia) at once; deliver as quickly as possible consistent with cleanliness and preservation of the soft parts; bleed, removing from 300 to 700 c. c., as may be indicated; infuse, giving from 500 to 1000 c. c. of salt solution, depending upon the amount of blood withdrawn and the character of the pulse. This may be repeated as many times as indicated:

Croton oil gt. i-gtt. ii, with olive oil ʒ i-ʒ ii, followed by magnes. sulphate ℥ss in saturated solution every hour until effectual as a purgative.

Other conditions treated symptomatically.

The use of veratrum viride is discussed, and while no definite conclusions are reached, the author believes that better results can be obtained by the method outlined above, although it may be used to advantage in the country, where conditions are not so favorable for immediate operation.

THE IMPORTANCE OF AN EARLY DIAGNOSIS IN CANCER OF THE UTERUS.

In the *Southern Clinic* for December, 1904, Dr. T. A. Ashby, of Baltimore, contributes a paper with the above title. The author attempts to show that there are few diseases coming under the notice of the general practitioner of medicine in which an early diagnosis is attended with more satisfactory results than cancer of the uterus. He claims that recent statistics show a marked increase in the number of cases of uterine cancer with the growth of modern civilization, and that many lives are yearly sacrificed by a disease which could be eradicated in the early stages of development were a prompt diagnosis made and a radical operation for the removal of the disease promptly instituted. His experience has shown

the great value of the radical operation when it has been possible to remove the area of tissues involved. To be effective and prophylactic the radical operation must reach beyond the cancer-cell infiltration, and this fact makes the early diagnosis a matter of primary importance to the surgeon as well as patient. Guided by his personal experience, the author attempts to show why it is that the surgeon meets with so few cases of uterine cancer in their primary stages. Cancer of the uterus is most commonly found during the child-bearing period of life and in the child-bearing woman. In its early stages its symptoms are obscure and are associated in the mind of the average woman with disturbances of her menstrual function of a temporary character. Hemorrhage is the most common symptom, and unless it is alarming or continuous the patient usually disregards it, or if she consults a physician, does so in such a way as to disarm suspicion or to decline a proposition looking to an investigation of her true condition. Valuable time is in this way lost by the hesitating policy of the patient, and extensive development may already have taken place in the disease before its most alarming symptoms—pain and foul discharge—become apparent. In this way valuable diagnostic symptoms may be overlooked before the patient seeks medical advice. No disease is more treacherous and indulgent to the suspicions of the patient and careless medical observer than uterine cancer. Hemorrhage and even foul discharge may continue for months before an investigation is sought by the patient or urged by the family physician. These symptoms are more apt to be overlooked at or near the time of the menopause. The storms which occur in the lives of many women at this period of life are usually regarded as incidental to the subsidence of function rather than the outcome of pathological conditions. Hemorrhage recurring one, two or three years after the complete suspension of menstruation is often viewed in the same light.

The clinical diagnosis of uterine cancer is often difficult in its primary stages. The microscope is at this stage the only safe reliance; still there are certain clinical features in the behavior of the disease which go a long way to confirm suspicion and to suggest the importance of a more thorough investigation. The cause of uterine hemorrhage should be sought in every case. In non-malignant diseases of the uterus, if we except certain forms of fibroid growths, hemorrhage seldom recurs after a good curettement of the uterine cavity. This is not the case with cancer of the cavity of the uterus. Here recurrence is the rule. The malignant action is a progressive action, whilst innocent conditions, as a rule, improve under proper treatment.

THE MIDWIFE PROBLEM.

Dr. Guy Steele (*Maryland Medical Journal*, January, 1905) says we should begin by enforcing the law requiring registration. Let the few who refuse be fined, and the rest will comply or cease business. Many midwives have given up their business rather than go to the small trouble of making monthly returns. We should be able to fix a day—say a year later than the act of assembly—after which all who propose to begin the practice of midwifery must obtain license by passing an examination. This examination should be plain and practical. Details should be left with a board of examiners. The enforcement of the law should be placed in the hands of the executive officer of the State Board of Health. It should be the duty of the county health officer to report violations of the law to the secretary of the State Board. Lectures must be brought to the candidates. A combined board of lecturers and examiners should be appointed—say one for each of three counties for the State at large and a suitable number for Baltimore—who shall meet and formulate a set of examination questions for the whole State. The lectures should be so arranged as to cover the questions for examination. Each lecturer should twice yearly visit the county-seats. Just before a course an examination should be held on the preceding course. A certificate of proficiency should be given to those who pass entitling them to attend cases of labor (but not for pay) under the supervision of a physician. The last course should cover the practical side of obstetrics, and the final examinations should test the ability of the candidate to manage cases of normal labor on her own responsibility.

A NEW METHOD OF ETHER ANESTHESIA.

A new method of ether anesthesia is now in use in the University Hospital. No claim for originality is made, as the method is in use in other hospitals, but as its use is by no means widely prevalent, it is described. No cone is used, but an ordinary Esbach inhaler covered with a double layer of stockinette, and the ether is dropped from an ordinary chloroform dropper. The eyes are

covered with moist absorbent cotton. The inhaler is closely covered by gauze, except a small opening through which the ether is dropped, and this is an important matter, as some difficulty will be had in getting the patient anesthetized if too large an opening be left in the inhaler, as it allows a too free admixture of air.

This method has the following advantages: The patient is gotten to sleep quickly—often complete anesthesia is gotten in four minutes; it obviates largely the sensation of strangling that the ordinary cone causes, and the patient goes to sleep with much less struggling than is ordinarly seen. As there is little struggling, there is consequently very much less bronchorea.

The unpleasant after-effects of ether are not so evident, the patient wakes sooner, and has much less nausea and vomiting.

A CASE OF SO-CALLED TRAUMATIC ASPHYXIA.

Professor Randolph Winslow reports in the *Medical News* for Febuarry 4, 1905, the case of a man, 22 years old, who was caught between the ceiling and top of an elevator car. Thus confined, sitting on his heels, with head forced down on the car, he did not loose consciousness, but suffered much pain and difficulty of breathing, and felt as if his head and chest would burst. After some moments, being released, he was brought to the hospital with pulse 120, respiration 40, much pain, bloody expectoration, some epistaxis, fracture of fourth, fifth, and sixth ribs on the left side, some cough, some emphysematous infiltration of connective tissue, contusion on right ear, laceration around rectum from heel, extensive extravasation of both conjunctivae, and the most noteworthy feature—a bluish punctiform discoloration of head, face, and neck, stopping short at level of cricoid cartilage. It did not disappear on pressure. Head and face were swollen. The temperature, normal at first, rose same day to 100.8° F., but was normal after third day. The discoloration gradually disappeared, and patient left hospital almost free from it on the twelfth day. A piece of the discolored skin was removed and examined, and found to be normal.

IMPORTANCE OF TESTING OCULAR MUSCLE BALANCE FOR NEAR AS WELL AS FOR DISTANT VISION.

Dr. Samuel Theobald (1867), in the *Johns Hopkins Hospital Bulletin* for January, 1905, says that although in recent years so much attention has been paid to anomalies in the ocular muscles, the significance of the muscle balance in near vision has not received the recognition it deserves. In every case of asthenopia this should be tested for near vision. Frequently nothing significant is elicited, but occasionally it reveals a fault which must be taken into account if the patient is to obtain complete relief. The test requires but a few moments, and is much too valuable to be ignored. T. uses the simplest contrivances for the vertical-diplopia test—a prism of 7° from the trial case, and upon a card attached to a rod 12 inches in length a small object calculated to stimulate accommodation, such as an asterisk, and for discovering hyperphoric faults a multiple Maddox rod with a Schild electric light.

SOME TYPHOID EPIDEMICS STUDIED BY LABORATORY METHODS.

Dr. Wm. Royal Stokes, City and State Bacteriologist, has a paper on this subject in the *Journal of the American Medical Association* of February 25, 1905. In several epidemics the bacteriologic examinations enabled the State Board of Health to locate the sources of the infection. In the first the colon bacillus was demonstrated in the spring used by the portion of the city infected; in the second the water supply was from artesian wells and was pure, yet the colon bacillus was found in the water supply in the houses. The infection was traced to a spring in a ravine, the water of which was used occasionally to flush out the wells when they became clogged with sand and gravel, and colon bacilli were found in it.

In the next epidemic the 61 cases all took milk from the same dairy, three other supplies in the town being used with impunity. Examination showed that the dairyman's wife and son had both had typhoid fever with Widal reaction, but had continued for a time to milk their cows. The wells on the place showed the colon bacillus.

In a fourth outbreak it was observed that the females in a factory took typhoid fever, while the males escaped. The drinking water was the same for both. The explanation was that the men went off to the saloons to get beer with their lunch, while the women used a sandwich and milk. No typhoid could be found at the dairy supplying this milk, but the milk showed concentrated fecal pollution, and the water from the wells also contained the colon bacillus.

In the next case two attacks of typhoid were

traced to the use of infected water for one day. In the last outbreak the infection was from a spring situated down the hill from an infirmary where a student had been ill with typhoid fever. The sewer pipe from the infirmary ran within 20 feet of the spring. The water of the spring contained colon bacilli. Those at the institution used other supplies, did not suffer, and as soon as the infected water was discontinued the outbreak ceased.

HISTORY OF THE CLINICAL RECOGNITION OF GASTRIC ULCER.

Dr. J. C. Hemmeter (*Journal of the American Medical Association,* January 7, 1905) says there is nothing to show that Hippocrates knew of this pathological condition. The same seems to be true of Galen. The first clinical record of it is in a sixteenth-century author, Johann Bautrin, a perforation being found, p. m., in the middle of the stomach near the fundus. Records of cases of healed ulcer date from the same and the next centuries. To Matthew Baillie belongs the credit, in 1793, of having first accurately described the anatomical peculiarities of the simple gastric ulcer, of which he gave three good engravings in 1799. By far the best description to date was by Voigtel at the beginning of the eighteenth century. Cruveilher for the first time clearly distinguished gastric ulcer from cancer of the stomach and gastritis, 1829-35. In 1839 Rokitansky gave an analysis of 79 cases. The designation ulcus ventriculi was first used by Johann Peter Frank (1745-1821), to whom we also owe the elements of the modern treatment of the disease—insistence on absolute rest in bed, application of snow or crushed ice to the stomach, great regard for dieting (milk and bouillon in small portions). Since the description of Cruveilher, Rokitansky, and Virchow, the pathologic and clinical conceptions have received no notable advance. The first surgical intervention was by Rydigier in 1881.

BOOK REVIEWS

Handbuch der Geschichte der Medizin. Begründet von Dr. Med. Th. Puschmann, Weiland Professor an der Universität in Wien. Herausgegeben von Dr. Med. Max Neuberger, Docent an der Universität in Wien, und Dr. Med. Julius Pagel, Professor an der Universität in Berlin. Bund I und II. Jena: Verlag von Gustav Fischer. 1902-1903.

This great work, in which all the research of previous times into the history of medicine is summed up and contained with that industry and care which distinguish German writers, marks an era in medical literature. It is unquestionably the most complete and exhaustive presentation of the subject available as yet to the medical student. Founded in 1897 by the lamented Puschmann, long professor of the history of medicine at the University of Vienna, in association with a number of collaborators, it has far outgrown the proportions originally designed for it, viz., three volumes, and has now, as we learn from the publishers, reached the twelfth number, with several other numbers still to appear.

Puschmann died on the 28th of September, 1899, having written only the introduction to the work, which is published unchanged at the beginning of the first volume. By his will he desired that his pupil, Dr. Max Neuburger, should succeed him. The new editor has associated with himself, besides his special co-editor, Dr. Julius Pagel, many men distinguished in this field, of whom we may mention without invidious distinction perhaps Bloch of Berlin, Fuchs of Dresden, Arndt of Greifswald, Chiari of Prague, Oefele of Neuenahr, Von Töply of Vienna and others already known to fame.

The first volume deals with antiquity and the Middle Ages. With the second begins the consideration of modern times, with many excursions into antiquity in elucidation of the various themes. According to the plan of the founder, the presentation of modern medicine is given under the two great divisions, biology and pathology. An introduction of 152 pages by Neuburger is a most helpful addition to the vast subject. It is useless to say, after what has been said, that this work is necessary to anyone who would write of or go at all deeply into the subject of the history of medicine, and we cannot but pity those who are debarred from a participation of its treasures by ignorance of the language in which it is composed and in which so much else that is the best in literature and science is given to the world.

E. F. C.

Twenty-first Annual Report of the Kensington Hospital for Women. Charles P. Noble, M.D., surgeon-in-chief. Philadelphia, 1904.

THE THYROID AND PARATHYROID GLANDS. By Hubert Richardson, M.D., late Pathologist to Mount Hope Retreat; Pathologist to Maryland Asylum and Training School for Feeble-Minded Children; Demonstrator of Physiologic Chemistry, University of Maryland. Philadelphia: P. Blakiston's Son & Co. 1905.

This illustrated monograph of 261 pages, with 77 half-tone illustrations, is an opportune presentation of a subject which illustrates some of the greatest triumphs of modern medicine, but has not previously been brought within the compass of a single volume. Organotherapy is not a new idea, as Dr. Richardson shows, but the application of it to ductless glands, and our knowledge of "internal secretions" is due to Brown-Sequard, who argued that every gland of the body produces a secretion which is necessary for the well-being of the organism. Although he failed with his "orchitic extract," the impulse went on, as the result of which two glands at least—the thyroid and suprarenal—have taken a definite place in medicine. It is quite certain, as the author says, that similar results are impending with other analogous organs, like the testicle, ovary, thymus gland, spleen, bone-marrow, pituitary body, brain, cord, liver, prostate, etc.

We have noted many interesting points here and there, but our space does not permit us to extend this notice with too much detail. It is noticeable, however, how wide seem to be the uses of the thyroid.

Besides cretinism and myxedema, there are proofs of its beneficial action in fibrous goiters, infantilism, certain forms of glycosuria, senilism, Bright's disease, epilepsy, menstrual disturbances, certain convulsive disorders, especially of pregnancy, impotence, certain diseases of the skin, as psoriasis, mental diseases, possibly hemorrhage and paralysis agitans. It is rather noteworthy that Americans seem to have figured so little in this field. For of the 84 authorities writing since 1900 and enumerated at the end of the book, not a single one is American. Yet the pages of the work show that American observers have not been ignored by the author. We are rather surprised to find no mention of the partial extirpation of the thyroid for exophthalmic goiter done by Halstead—we believe with marked success. In this affection—"Basedow's disease," as it is here termed—the opinion of today is in favor of surgical interference, and yet strophanthus and belladonna have their uses, and desiccated suprarenal and Lugol's solution were administered by the author and others with success.

As Dr. Charles G. Hill points out in his preface, Dr. Richardson possesses peculiar qualities for writing such a work by reason of his capacity for research, his knowledge of several languages and his general versatility. That he has contributed a valuable addition to medical literature there can be no doubt. E. F. C.

THE DOWNES ELECTROTHERMIC CLAMPS: Further Experience in Their Use in the Treatment of Cancer of the Uterus. By Charles P. Noble, M.D.

THE TREATMENT OF SOME FORMS OF ANEMIA. A Clinical Lecture Delivered at King's College Hospital. By Nestor Tirard, M.D. (Lond.), F.R.C.P., of London.

THE NATURE OF THE INDICATIONS FOR OPERATION FOR FIBROID TUMOR OF THE UTERUS. By Charles P. Noble, M.D.

OVERLAPPING THE APONEUROSES IN THE CLOSURE OF WOUNDS OF THE ABDOMINAL WALL. By Charles P. Noble, M.D.

NOTES AND ITEMS

The February meeting of the Library and Historical Society was held in Chemical Hall the 9th ult. Dr. T. B. Futcher of the Johns Hopkins Medical School read a paper on "The Dancing Mania of Europe and Epidemic Convulsions in Kentucky," showing much research, and Rev. Harris E. Kirk gave a charming and (as Dr. Wilkinson observed) a truly Ruskinesque address on "Literature." Mr. D. W. Burroughs and Dr. E. F. Cordell read sketches of the law and medical libraries, respectively, which had been prepared for publication at the request of the United States authorities in Washington. The attendance was disappointing, and we hope the students and alumni will form better resolutions for the April meeting.

Alumni of the Maryland College of Pharmacy (now the School of Pharmacy) should remember that they are now alumni of the University of Maryland. As such they are eligible to all the rights and privileges of the graduates in other departments, such as membership in the General Alumni Association. Should they not also share

the responsibilities connected with the possession of these privileges and join with us heartily in our efforts to build up the old University?

The General Alumni Association of the University, founded January 21, 1903, was incorporated on February 4 by Judge Henry Stockbridge, R. W. Beach, J. L. V. Murphy, Thomas A. Ashby, and Eugene F. Cordell. The purpose of the Association is the formation of closer relations between the various departments and the advancement of the interests of the University. Besides the incorporators, the directors for the first year are N. Winslow Williams, William Whitridge, I. Edmonds Atkinson, George L. Deichman, Charles E. Sadtler, Wilmer Brinton, and Henry P. Hynson.—*Old Maryland.*

The following physicians have been recent visitors to the University Hospital:

Dr. Wade H. Byerman, Germantown, N. C.
Dr. E. B. Darling, Lauraville, Md.
Dr. Joe Whitehead, Rocky Mount, N. C.
Dr. C. R. Ogden, Clarksburg, W. Va.
Dr. J. L. Hanes, Winston-Salem, N. C.
Dr. Byerly, Laurel, Md.
Dr. A. Williams, Elkridge, Md.
Dr. W. J. Buppert, Woodlawn, Md.
Dr. J. B. Wallace, Mt. Holly, N. C.
Dr. G. C. Winterson, New Windsor, Md.
Dr. N. Peck, Clarksburg, W. Va.
Dr. J. R. Hunt, Laurel, Md.
Dr. Allen Devilbliss, Toledo, Ohio.
Dr. H. G. Holloway, Jacksonville, Fla.
Dr. Charles Hardwick, Mercantile Navy.
Dr. A. F. Cronk, Mt. Airy, Md.
Dr. J. G. Dubois, Gambrill's, Md.
Dr. Harry Tull, Salisbury, Md.
Dr. P. H. Taws, Smith's Island, Va.
Dr. S. D. McPherson, Haw River, N. C.
Dr. C. H. Ice, Mannington, W. Va.
Dr. F. Lee Hughes, Forest Hill, Md.
Dr. J. H. Ross, Trappe, Md.
Dr. H. F. Bevan, Grantsville, Md.
Dr. W. W. Beall, Rock Hall, Md.

A new portico is under process of erection in connection with the Greene street wing of the hospital. It is constructed of iron and will have a length of 100 feet and 14 feet width, with three floors. An accident room and sun parlors will be connected with each floor. The cost of construction will be $3500, which is borne by the Woman's Auxiliary Board of the University Hospital.

Dr. R. H. Johnston, demonstrator of diseases of throat and nose in the University of Maryland, was married December 21 to Miss Mary Page Small of Baltimore.

Dr. Harry Tull of the class of 1900 has removed from Nanticoke City to Salisbury, Md., where he will in future devote his attention largely to surgery.

Dr. W. R. Stokes was re-elected bacteriologist of the State Board of Health, and Dr. Marshall L. Price, medical assistant for the year 1905.

The Masons of Maryland will erect a monument at Cumberland to the memory of Dr. Charles H. Ohr.

Dr. Julius A. Johnson (1871) has been elected president of the Talbot County Medical Society.

Dr. W. S. Nelson of Utica, N. Y., has just completed a post-graduate course at the University.

Dr. N. Peck of Clarksburg, W. Va., is taking a post-graduate course at the University.

DEATHS

Dr. Alphonso A. White (1853), surgeon of the Third and Eighth Maryland Volunteer Infantry during the Civil War, died in Baltimore December 18 from apoplexy, aged 73.

Dr. Cyrus McCormick (1868) died at Berryville, Va., January 3, aged 59.

John Bagley, M.D. (1867), suddenly from heart disease, at Lake Village, Ark., January 29, aged 61 years.

James McElderry Mullikin, M.D. (1842), at Collington, Prince George's county, Maryland, February 1, aged 85 years.

William W. Wilson, M.D. (1866), at Glenarm, Md., February 2, aged 78 years.

Milton Elmer Hammer, M.D. (1890), at Baltimore, February 24, aged 39 years.

Edward A. Hering, M.D. (1855), at Harrisonburg, Va., February 25, aged 78 years, of paralysis. Born in Pennsylvania; moved to Virginia 1879.

Dr. Robert P. Lake (1849) died recently at Locust Dale, Va., aged 82.

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I. B. HARGETT, M. D., Cleveland, Ohio.

I used your Resinol Ointment a short time ago in a most intractable case of pruritus ani which defied every other remedy used. It was relieved in a very few applications. I regard your preparation as a triumph over this detestable symptom. J. G. KELLY, M. D., Hornellsville, New York.

I tried your Resinol Ointment on myself. I had suffered from pruritus ani, or marginal eczema, for 25 years, and had tried many remedies without any relief, until Resinol proved soothing and stopped the itching instantly. J. T. HICKMAN, M. D., Mt. Jackson, Virginia.

Resinol Ointment is the first local application I have found that has given lasting and gratifying results in the treatment of pruritus vulvæ. DR. GRACE WINTERSTEEN, Harrisburg, Pennsylvania.

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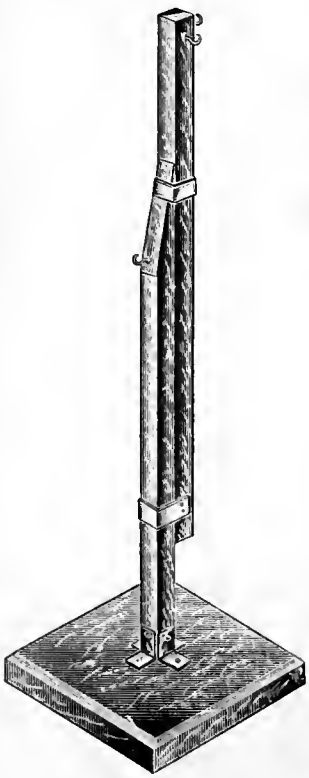

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DIRECT INGUINAL HERNIA, WITH PROTRUSION OF THE BLADDER—WOUND OF THE BLADDER—RECOVERY.

BY RANDOLPH WINSLOW, A.M., M.D.,
Professor of Surgery, University of Maryland.

Of the two forms of inguinal hernia, the direct variety is of comparatively infrequent occurrence, the proportion of cases in comparison with the indirect or oblique variety being variously given by authors as from one to seven to one to 17. It certainly appears to me to be much less frequent than these figures would indicate. That the condition does exist, however, I have had occasion to verify both on the living and dead subject. Direct inguinal hernia is always an acquired, and never a congenital form of rupture; consequently it is found in full-grown and mature adults. It derives its name from the fact that it appears at the external abdominal ring, pushing the structures of the abdominal wall before it, and not traversing the inguinal canal. It bears a definite relation to the deep epigastric vessels, being always found to the inner side of these structures, whilst the oblique or indirect form of inguinal hernia always protrudes through the internal abdominal ring to the outer side of the epigastric vessels. The coverings of the two varieties of hernia also differ, those of the oblique variety being similar to those of the spermatic cord, viz., skin and superficial fascia, external spermatic fascia, cremasteric fascia, infundibuliform fascia, preperitoneal fat and peritoneum, whilst the direct variety substitutes the conjoined tendon for the cremasteric fascia and the fascia transversalis for the infundibuliform fascia. In the development of the direct inguinal hernia the advancing hernia either pushes the conjoined tendon of the internal oblique and transversalis muscles directly before it, or passes through an aperture in the conjoined tendon, or escapes at the external border of this tendon. The spermatic cord is found to the outer side or in front of the sac in the direct, whilst it lies behind the oblique form of hernia.

Clinically the direct inguinal hernia forms a globular swelling near the pubis and directly behind and through the external abdominal ring, whilst the oblique variety first appears at the internal abdominal ring; then follows the oblique inguinal canal, and finally protrudes at the external ring, being more elongated and sausage-shaped than the direct. A finger inserted into the hernial orifice passes almost directly backward in the direct variety, whilst it passes outwards and upwards before going through the internal ring in the oblique form. When, however, either variety assumes large proportions, it may not be possible, clinically, to differentiate them. It is owing to this difficulty in distinguishing the two varieties of hernia from each other in some cases that so much stress has been laid upon the necessity of making our incisions through the constricting rings in strangulated hernia upwards towards the umbilicus in order to avoid cutting the epigastric vessels. The contents of the hernial sac usually consist of intestine or omentum, but may contain also a portion of the bladder, which is my excuse for reporting the following case:

S. T. W.—Negro man, aged 54 years, single, and a driver by occupation, was seen by my son, Dr. Nathan Winslow, in consultation with Dr. Roger Brooke of Sandy Spring, Md., about the middle of September, 1904. He had at that time an incarcerated hernia which was difficult to reduce and which was diagnosticated by Dr. Nathan Winslow as a direct inguinal hernia. He entered University Hospital, Baltimore, on September 23 for an operation for the radical cure of the hernia. There is nothing suggestive in his family or previous history. About two years ago he noticed a movable lump in his right groin which pained him at intervals, especially upon heavy lifting. About six weeks ago the swelling increased in size, with an augmentation of pain and occasional vomiting. After the reduction of the hernia these symptoms subsided, and he sought to prevent a recurrence by undergoing an operation. His general health was unimpaired. A rather globular swelling of considerable size was

found on the right side near the root of the penis, which was reducible, but not so readily reducible as is ordinarily the case in inguinal hernia. No suspicion was entertained that the bladder formed a portion of the hernial protrusion, as there had been no symptoms referable to the bladder. An operation for the radical cure of the hernia was undertaken on September 26, 1904. The usual incisions for a Bassini operation were made, and when the sac was exposed it was found to protrude through an opening on the inner side of the epigastric vessels, thus corroborating the diagnosis of direct inguinal hernia. The sac was very adherent to the surrounding tissues and was isolated with difficulty. There were firm adhesions to a mass on the inner side, which looked like condensed fatty connective tissue. After the isolation of the sac it was opened, ligated and cut off, and then a cystic swelling was discovered, which was thought to be a cyst connected with the cord. This was incised, and some amber-colored fluid escaped which had the odor of urine. A finger introduced into the opening passed down behind the pubis into a smooth-walled cavity which proved to be the bladder. The wound was immediately cleansed with sterile water, and the incision into the bladder was closed with three layers of sutures, catgut being used for the mucous membrane and silk for the two outer rows. The apex of the wound in the bladder was fastened to the inner angle of the abdominal incision. A short incision was also made between the recti muscles into the space of Retzius for the purpose of gauze drainage, and gauze was also tucked in at the inner angle of the belly wound. The operation was then completed in the usual manner up to the point at which the gauze drain was placed. An attempt was made to drain the bladder by means of a soft rubber catheter, but this did not succeed, and the man was directed to empty his bladder voluntarily every two or three hours. The man had no serious symptoms subsequently, though there was some painful micturition of blood-stained urine for awhile. This gradually passed off. There was no leakage of urine at any time, nor was there any marked febrile reaction, and he left the hospital practically well.

In a considerable experience with operations for the various forms of hernia, this is the first time that I have found a protrusion of the bladder along with the hernia or forming a portion of the contents of the hernial sac, though the condition occurs more frequently than one might think. About the time of the occurrence of my case I heard of a similar case occurring in the practice of a prominent surgeon of this city, which was, fortunately, recognized before the bladder was injured. The subject of injuries to the bladder during operations for hernia has received but scant notice from surgical writers. The most elaborate article upon this subject accessible to me is that by Dr. B. Farquhar Curtis of New York in the *Annals of Surgery*, Vol. XXI, page 631, in which all the literature from remote times to 1895 is reviewed. Dr. Curtis also tabulated all the cases of hernia of the bladder known to have occurred up to that time, 41 of which sustained injuries during operations and 17 were recognized before the bladder was wounded. In an article upon "Hernia of the Bladder, Complicating Inguinal Hernia," by Dr. Francis J. Shepherd of Montreal, published in the *Annals of Surgery* for December, 1904, the statement is made that in 1 per cent. of cases of inguinal hernia there is an accompanying hernia of the bladder. The condition is therefore of sufficiently frequent occurrence to make the subject one of practical interest. Dr. Shepherd also publishes four cases of his own, in two of which the bladder was injured. Two of his cases were complications of direct inguinal hernia, and one of the eight new cases recorded by Dr. Curtis also accompanied a direct hernia. In 13 cases of hernia of the bladder accompanying inguinal hernia, and recorded by Curtis, Shepherd and myself, there have been four in which it is definitely stated that the direct form of hernia existed. It seems to be more than a coincidence that this should be the case, as the bladder is manifestly in closer relation with a direct than with an oblique rupture. The extraperitoneal surface of the bladder is the portion usually found in the hernia, but in some cases the intraperitoneal portion is found within or forming a portion of the hernial sac. One would naturally think there could be no difficulty in recognizing the presence of the bladder in the hernia, but as a rule its appearance is markedly altered, and mistakes are only too liable to occur. If one has made the mistake once he will not be very likely to do so again, as he will view with suspicion any abnormal-looking tissue found in close connection with the sac. The bladder may be wounded in a variety of ways — by punctures with a needle, by tearing during the isolation of the sac or by incision—and the traumatism may be recognized at once or not until there is an escape of urine from the wound. The mortality of the cases reported by Curtis is 25 per cent.,

but this is doubtless too high at the present time, and it should not be greater than that of an operation for suprapubic cystotomy. A rent in the bladder should be sutured at once, and a small drainage tube or piece of gauze introduced down to the injured point. The mucous membrane should either not be sutured at all or catgut sutures may be employed. The muscular and peritoneal coats should be closed with two rows of silk sutures, not penetrating the whole thickness of the bladder wall. Drainage of the bladder is not necessary, as the patient can empty his bladder every two hours, and in this manner prevent any undue tension on the sutures.

TYPHOID FEVER COMPLICATED BY MULTIPLE LIVER ABSCESSES.

By J. E. Gichner, M.D.,

Associate Professor of Clinical Medicine, University of Maryland.

Without commenting upon the propriety of the above title, I will narrate the following case, with autopsy findings, and let the reader decide whether we were justified, from a clinical point of view, in using the above title:

H. P., age 38, laborer, residing in this city, was brought to the hospital October 4, 1904. At the time of entrance he appeared very ill and was not able to sit up in bed for physical examination. Had been ill for two weeks, at times delirious. The family history was quite negative. His present illness commenced insidiously with malaise, loss of appetite, headache, backache and indigestion. Has had no nose-bleed, cough and no diarrhea.

The past history of the patient will perhaps throw some light upon the pathological findings and will perhaps explain the special selective action of his typhoid disease on the liver. Four years previous to this attack the patient had had a well-marked case of syphilis; had then treatment only for three months; never had typhoid fever before; had malaria several times; no other diseases. In regard to his habits, he indulged freely in both whiskey and beer.

Physical examination was as follows: Patient looks extremely pale; answers questions in a vague manner; has slight signs of emaciation; skin warm to touch; face flushed; cheeks and temples sunken; pupils equal in size and react normally to light and accommodation; mouth, lips and mucous membranes of good color; tongue protrudes in median line — clean, moist and slightly tremulous; chest fairly developed; clavicular fossae not depressed; costal angle 80 degrees; expansion poor; breathing chiefly thoracic. Patient complains of pains in abdomen on deep inspiration; percussion note over chest and axilla negative; tactile fremitus equal on both sides; auscultatory signs are in front of chest negative; some subcrepitant rales heard in axillae. In the back percussion note over right lung from angle of scapula downward shows diminished resonance, especially marked at base; breath sounds over this area are accompanied by fine, dry and moist rales; vocal fremitus diminished.

Heart.—P. M. C. I. in fifth interspace in mammillary line. Both sounds at the apex are feeble; first sound is accompanied by soft systolic murmur which can be traced into left axilla; second pulmonic sound is accentuated.

Abdomen.—Hepatic flatness begins at sixth rib in nipple line and extends to costal margin; abdomen is markedly tense and tympanitic; edge of liver and spleen not palpable; patient complains of pain on deep palpation everywhere, but especially in right lumbar region; a few small hyperemic areas resembling rose spots are seen; genitals and lower extremities normal; reflexes normal.

Blood examination gave us a leucocyte count of 10,000; hemoglobin 60 per cent; urine analysis at this time negative.

Temperature on entrance was 103°; pulse 104, of good volume, medium tension, normal in rythm; respiration 28.

From October 4 to October 11 temperature ranged between 104° and 100°, always brought down by sponging. On October 11, after sponging to reduce temperature of 104⅗°, patient had a severe chill of 20 minutes, with a drop of temperature to 99⅗°, with subsequent rise on next day to 106⅗°; again with marked chill and drop to 98°; subsequent rise to 103°. At this time the heart showed marked weakness, and had to be stimulated with digitalis and strychnia, also with ice cap over precordia.

After these repeated chills we took blood count and found a leucocytosis of 20,000; blood examination for Widal reaction was positive in dilution of 1 to 50 on October 7.

The patient, who had been delirious and restless, especially at night, became somewhat better after these repeated chills and marked rises of temperature. His abdominal extension somewhat diminished, but tenderness and pain, especially in

right hypochondrium and lumbar region, continued.

At this time there was also noticed a slight yellowish tinge to the skin and sclerotics. On October 13, with pulse of 100, temperature102°, respiration 24, we noticed a distinct well-outlined mass extending from the ribs downward almost to the umbilicus. It occupied the whole of the epigastric region, part of the umbilical and right-lumbar region, and extended to the left nearly to the lumbar region. This mass was extremely tender to the touch, immovable, and we took it to be liver, inflamed and adherent to the abdominal peritoneum. From this time on the patient was semiconscious, with pain in abdomen and jaundice growing worse; also pulse, while not more rapid, was getting perceptibly weaker and windy.

Examination of the chest on October 19 showed dullness in right axilla from fifth rib downward; also dullness in back from angle of scapula to base. Tactile fremitus diminished.

On October 20 hypostatic pneumonia developed in both bases; heart gradually failed, and the patient died at 2 A. M. October 21.

Autopsy.—H. P. of No. 2 medical ward, 9½ hours after death. Length of body 145 c. m. showing marked emaciation; scar on left patella 2½ c. m.; skin over entire body jaundiced; in peritoneal cavity about 300 c. c. of bile-stained fluid was found. The small intestine was covered by plastic fibrinous exudate, agglutinating the coils, but easily pulled apart; appendix normal; liver extends 10 c. m. below ensiform appendix into left hypochondrium, filling it almost entirely; left lung bound down by adhesions which are fibrinous and easily broken up; pleural cavity contains 100 c. c. sero-fibrinous straw-colored fluid; right lung bound down posteriorly in its whole extent by firm fibrinous adhesions; right pleural cavity is free from fluid; no pericardial adhesion; apex on level with upper margin of fifth rib. The heart muscle appears soft, thin and flabby. The mitral valves show roughening and thickening of the edges of leaflets; all other valves normal. Just above and between two of the leaflets of the aortic valves there is a circular area about 1½ c. m. in diameter, thickened, cartilaginous, contracted, depression of surface of intima of the aorta showing healed ulceration; coronary arteries normal; left lung normal, except in back of lower lobe there is a hypostatic congestion; right lung, lower lobe, has an area of 5 c. m., markedly congested; spleen measures 14x7x3 c. m; weight 180 grams; pale gray in color; shows no enlargement of trabeculae; liver adherent by firm adhesions to abdominal wall; is removed with difficulty, and in doing so an abscess cavity is broken into and about 100 c. c. of greenish-yellow pus evacuated. On convex surface of right lobe of liver three large abscess cavities, separate and distinct from one another, about 7, 5 and 4. c. m. in diameter, are broken into; liver weighs 2000 grams and measures 28x20x7 c. m. The abscess cavities show a honeycombed appearance. Surrounding the abscess liver tissue shows marked hyperemia, beyond that fatty changes; stomach normal; small intestines show occasional hyperemic patches in the ileum; two well-defined, partially-healed ulcers found in caput coli; no enlargement of mesenteric glands found.

Had the subsequent bacteriological examination of the contents of the abscesses not revealed the presence of the bacillus typhosus of Eberth in pure culture, we could have been in doubt as to the correctness of our diagnosis, as the case showed absence of swelling or inflammation of the intestinal and mesenteric glands, also of typical recent typhoid ulceration in the intestines.

In conclusion, I wish to thank Dr. Gassaway for notes and careful attention to the case.

LOBAR PNEUMONIA—THIRD-DAY CRISIS.

By J. Dawson Reeder, M.D.,
Clinical Assistant, University of Maryland.

As to lobar pneumonia, it is to be remembered that this is less frequent (though not altogether) in the aged and in children under five years. Between 5 and 60 years there is very little diagnostic dependence to be placed in age. The mode of onset is different from broncho-pneumonia—lobar developing abruptly with chill, lobular coming on insidiously, usually as a secondary infection. Lobar is usually one-sided and limited; bronchopneumonia is scattered over both lungs.

Definition.—It is an acute infectious disease, with characteristic lesion in the lung due to outpouring of a hemorrhagic fibrous exudate into the alveolar structure of the lung.

Symptoms.—They are too well known to occupy this space.

In acute pneumonia they are due to local and general infection. The former generally predominate. The onset is sudden, with a pronounced chill, which is frequently severe and pro-

longed. Ordinarily it occurs abruptly without any previous warning, but in some instances it is preceded by a day or two of ill-health. In children the chill is replaced by headache, nausea, marked vomiting, delirium or convulsions. Less frequently the onset is gradual, with a prodromal stage lasting from a few days to a week. These prodromes are indefinite, and may be such as accompany any infectious disease or may be constituted by symptoms pointing to the lung, such as cough, pain in the chest or slight dyspnea.

The fever rises rapidly and lasts from five to seven days, exceptionally terminating earlier and frequently later. Its decline is usually by crisis and is attended with great prostration; rapid improvement in the condition of the lung ensues, and convalescence quickly follows.

The course of the disease varies greatly, being influenced by the age of the patient, his habits and previous condition, as well as the virulence of the infection. As a rule, cases of frank croupous pneumonia are due to infection by the pneumococcus, while the asthenic varieties are associated with other bacteria.

Pain is a symptom of great frequency, and is always present when the lesion extends to the periphery of the lung. Sharp stabbing, agonizing in character and usually referred to the region of the nipple on the affected side.

Dyspnea is pronounced. In the early part of the disease it is due to the intense pain, attended with deep inspiration; later in the disease it is ascribed to the limitations of air space in the pulmonary lesion.

Sputum is characteristic and of diagnostic value; it is viscid and tenacious, so that it adheres to the vessel in which it is expectorated. Microscopically it contains red-blood corpuscles variously changed, but the corpuscular elements of the blood may be absent, the discoloration of the sputum under these conditions being due to the solution of its coloring matter.

It may also contain fibrous casts of the smaller bronchial tubes and alveoli. Various bacteria are found on staining, the pneumococcus as well as other bacteria.

Leucocytosis is a marked feature of the disease, but does not invariably occur. The leucocytes are increased from the earliest period of the disease, and this increase persists during the continuance of the fever. The number of white cells varies from normal to 35,000 or more, as the case reported by Cabot, in which the count was 94,000. The absence of a leucocytosis indicates a very unfavorable prognosis except in very mild cases. Anorexia, nausea and vomiting are not uncommon, and jaundice is not of infrequent occurrence.

Herpes is of such common occurrence in pneumonia as to possess diagnostic importance. The occurrence of the eruption is of especial value in cases of central pneumonia or in those cases where the limitation of the lesions renders diagnosis doubtful.

A case which came under my care in private practice some time ago gave the following history:

JAMES ROCKWELL, AGE 12 YEARS.

Mother and father living and in good health; has one brother eight years his senior, also in good health; two sisters living, both of whom are healthy, and one sister dead; cause of death, infantile diarrhea. Patient has had diseases common to childhood — measles, chicken-pox and whooping cough. About four years ago had scarlet fever, from which he fully recovered.

Present History.—On *November* 16, 1904, patient arose for breakfast and complained of slight headache, but did not seem to be very ill, and dressed for school. After playing around for a few minutes before breakfast went to the table, where, after drinking a cup of coffee, he was taken with violent convulsions and fell from the chair. I was summoned about 7.30 A. M. and found the boy in a second convulsion, which was typical of an epileptic. Patient was placed in bed, and after a careful examination found that he was completely comatose and pupils were widely dilated, with no response to corneal stimulation or light.

Bromide of potash was given by mouth, with result that I discovered that it was at once regurgitated through the nose. Hot bottles were placed around patient, and when I again saw him in four hours there was a spastic condition of all the flexer muscles. Thumb was tightly held between third and ring finger of each hand and forearms were flexed tightly upon the chest, thighs upon the abdomen and head thrown backward. I then inquired if there had been an injury either at home or in school, but could obtain no such history. Four hours later he was seen by Dr. Mitchell, and a careful examination of the chest at this time revealed nothing. There was a marked ptosis of the left eyelid, with tongue protruding through the left side of mouth, swollen and blue. The throat on inspection was dry and parched, and a complete paralysis of the right side of throat, causing the anterior pillar of this side to drop list-

less upon the tongue, and resembling a grayish membrane, due to the complete loss of tone and deficient circulation.

The spastic condition of the muscles was now more marked, and the temperature on the evening of the first day was 103° by axilla. At this time 30 grains of chloral was injected into rectum, and a hot mustard bath, with ice cap to head, resulted in a diminution of the spastic condition and a quick contraction of the pupils.

November 17.—Patient still in a comatose state, with less marked spastic contraction, but very restless at times; still unable to swallow, and upon careful percussion and auscultation there was a slight dullness extending over right lung from third to sixth rib.

Morphiæ Sulph. gr. ⅛ was given by hypodermic, followed by hot mustard poultice, and patient rested quietly after being bathed in a profuse perspiration.

November 18.—Patient very restless; spastic condition somewhat lessened, but all symptoms of cerebral lesion remaining; area of dullness in right lung more pronounced anteriorly, and posteriorly there was complete dullness of this area, with some signs of fluid in the chest, especially after patient had rested on right side for a few minutes. This area of dullness was found from axillary line posteriorly and from about the fifth to seventh intercostal space. Pulse at this time was 130° and very compressible; temperature per axillam 104°, respiration 28; features pinched, nose of a bluish tint, with dilatation of the alae in respiration.

A hot enema of soap and water was given, followed by a nutrient enema consisting of one raw egg, 15 grains table salt, peptonized milk three ounces and brandy one-half ounce. This was ordered to be repeated every four hours, and at intervals of two hours one-half ounce of whiskey with water was injected into the rectum. On the afternoon of November 18 patient was very restless, and paralysis had almost entirely cleared up except on right side of face. Pupils responded slowly to light, but patient was extremely cyanotic at intervals, and if placed on right side would breathe with great difficulty and would endeavor to cough (this was the first sound he had made for three days).

The area in the lung had now become completely consolidated, as evidenced on percussion and posteriorly-found symptoms which made the diagnosis of fluid almost positive. Patient was covered with a hot poultice of one well-known preparation, over which cotton batting was laid with a tight bandage. Left orders to continue the whiskey at intervals of one hour until cyanosis cleared to some extent. Four hours later patient was resting easy, breathing less labored and bathed in a profuse perspiration; pulse 110, respiration 24, temperature 99°. Patient could now be aroused, and talked in a delirious manner for some time. All signs of paralysis had completely disappeared, and he was able to swallow a little milk and whiskey when squeezed in the mouth from a handkerchief end.

On the morning of the fourth day found patient very quiet and all signs of paralysis cleared; was perfectly rational and asked for a glass of milk. Cotton jacket and poultice were removed, and examination of chest showed that resolution had taken place, as air was passing through the lung as far as could be made out, and there was lessened area of dullnes in back, which had been previously taken for fluid. On my afternoon visit of the fourth day I was surprised to find that the entire chest of this side had cleared and the dullness posteriorly had disappeared completely.

In presenting this case I wish to call attention to the peculiar onset which gave such an array of symptoms as to make a diagnosis impossible for 24 hours. At first we were inclined to look upon the case as one of meningitis or cerebral hemorrhage. Knowing that quite a number of infectious diseases are ushered in by convulsions in children, especially those of pneumonia and scarlet fever, we were able to reasonably exclude the latter from the history of having had an attack only four years ago. In the majority of cases the symptoms are so plain and physical signs so typical that it is difficult to overlook pneumonia if any degree of care is used in the examination of the patient. The error usually made is to mistake pneumonia for some other disease rather than mistake some other disease for pneumonia. Pneumonia with marked cerebral symptoms resembles cerebro-spinal meningitis. In both we may have abrupt onset, convulsions, delirium or stupor, opisthotonos and prostration. In meningitis there is a steady increase in the severity of the nervous symptoms for the first few days. In pneumonia they are, as a rule, most severe during the first 24 or 48 hours; then they gradually diminish, always subsiding at the crisis. The question sometimes arises: Are the symptoms functional? or whether meningitis also exists? Holt says: "There is probably no disease in which the patient is so ill and where

there is so little danger to life as in lobar pneumonia in a child over three years." In 1295 cases, chiefly hospital, there were but 39 deaths, or a mortality of 3 per cent. In nearly all the above cases death was due to complications or extensive disease, as where both lungs were involved.

The question that I have been unable to solve in the case here presented is: Was this a simple pneumonia, with cerebral symptoms preceding the physical signs, or was there a meningitis due to the toxic absorption, with secondary infection of the lung.

TYPHOID FEVER IN THE UNIVERSITY HOSPITAL.

By Charles Bagly, Jr., M.D.,
Resident Physician.

The following is a summary of the results obtained from a study of 70 cases of typhoid fever treated in the University Hospital during the past nine months from June 1 to March 1. The statistical information obtained from such a small number of cases is, of course, inaccurate, and will therefore be dismissed briefly. Of these cases 31.4 per cent. occurred during the summer months, during the autumn months 50 per cent. and during the winter months 18.5 per cent; 71.4 per cent. of the cases were members of the white race. The ages of the patients were as follows:

From 4 to 15 years, 18.5 per cent.; from 15 to 30 years, 57.1 per cent.; from 30 to 40 years, 15.7 per cent.; from 40 to 50 years, 5.7 per cent.; from 50 to 60 years, 1.4 per cent.; from 60 to 70 years, 1.4 per cent. Thus over one-half of the cases was found between the ages of 15 and 30 years. The youngest patient was four years, who died suddenly of cardiac asthenia; the oldest 61 years, who died suddenly of cardiac asthenia. History of a previous attack was obtained in 5.7 per cent.; malaise of from 1 to 7 days in 18.5 per cent.; malaise of from 1 to 14 days in 53 per cent.; headache was absent in only 9 per cent.; chill was observed (some time during the course) in 35 per cent.; bronchitis, 30 per cent.; appetite and tongue unaffected in 4 per cent.; abdominal tenderness and tympanites, 7.14 per cent.; constipation, 51 per cent.; diarrhea, 37 per cent.; epistaxis, 21.4 per cent.; spleen was palpable in 57.1 per cent.; delirium was present at some time in 38.5 per cent.; febrile albuminuria, 28.5 per cent.; acute nephritis, 8.5 per cent. The percentage of complications was as follows: Skin abscess, 4.2 per cent.; hemorrhage, 8.5 per cent.; relapse, 10 per cent.; perforation, 7.1 per cent.; recrudescence, 2.8 per cent; pneumonia, phlebitis and laryngeal ulcer, each 1.4 per cent.

Thus in four cases a history of a previous attack was obtained. It is very interesting to notice that this fact did not influence the course of the present attack, as one of the mildest cases occurred in one of these patients, duration being 25 days, with the fever never exceeding 102°. At the same time was found in this class one of the most severe cases that recovered.

As to the prodromal symptoms, the majority of the cases suffered from malaise for about two weeks. In six of the cases, however, the onset was sudden, usually being marked by a severe chill; two of these cases died.

Abdominal tenderness, you remember, was present in a large per cent. of the cases. In many instances this was associated with tympanites, but occasionally occurred when the latter was absent. This was particularly noticed in one case which was sent to the hospital as a case of appendicitis. The patient had been suffering with severe abdominal pains, persistent vomiting and constipation for five days. On examination of abdomen great tenderness was elicited, especially in right iliac fossa. The leucocytes were counted at 10 P. M., when they were found to be 10,000 per c. m. Five hours later they had increased to 16,000 per c. m. Fifteen hours after admission castor oil and a purgative enema were effectual and all symptoms of appendicitis vanished. The chills which occurred as an early symptom were of very little interest, being observed in about one-third of the cases; but in three instances they were observed late in the course of the disease without any apparent cause. In one case the temperature immediately rose from normal to 104°, returning again to normal in three days.

The delirium was chiefly of the low, muttering type. If aroused the patient would seem perfectly rational, but if not disturbed would lie in one position for hours. The percentage of cases in which the spleen was palpable is somewhat lower than usual, occurring in 57.1 per cent. in contrast with Osler's 71 per cent. In one case, in which the patient suffered a severe relapse, the spleen was very large, extending nearly to the iliac crest.

The febrile albuminuria, which occurred in 28.2 per cent. of the cases, caused very little trouble, and would have escaped observation had

not the urine been examined frequently. The same may be said of the cases in which acute nephritis occurred, all having recovered. Though the urinary findings were typical, in no case was edema of the tissues noted. In five cases complete retention was observed, it being necessary to catheterize every eight hours until late in the disease. In one case polyuria was present, nearly 4000 c. c. of light straw-colored urine being obtained in 24 hours.

Rose spots were present in a large percentage of the white patients, and even in some of the colored race they could be detected as small, raised spots which followed the usual course of the eruption. In several cases the rash covered the entire body. In three cases small skin abscesses were found during convalescence; as many as five appeared in one patient. Satisfactory results were always obtained by simple incision without drainage. We were unable to isolate the typhoid bacillus from the pus obtained from these abscesses. In no case were bedsores encountered.

A very interesting complication was observed in a patient who suffered a very severe attack, namely, laryngeal ulcer with mild edema of the glottis. In this case the first symptom was hoarseness, which increased until the voice was almost entirely lost. The ulcer was very small, situated at the base of the epiglottis at the attachment of the chords. This condition occurred in 5 per cent. of the Münich series. Typical relapse occurred in 10 per cent. of the cases. In three of these it occurred at the end of the second week of a mild attack. Other cases, however, were severe and protracted, the relapse occurring in one as late as the sixth week. In most of the cases the rise of temperature occurred after a normal temperature of two or three days. All of these cases recovered, though in some the relapse was very tedious. The duration of the relapse varied from 11 to 37 days. In two of the cases recrudescence was observed. In one patient the temperature had been normal for three days, when he had a severe chill, which was immediately followed by a temperature of 104°, gradually returning to and reaching normal in three days. Hemorrhage was a very annoying complication in five cases. There were also a few cases in which the stools were tinged with blood. In three of the cases the hemorrhage appeared during the latter part of the second week, one during the third week, and in the last during the sixth week. Death was the result of hemorrhage in one case. The marked fall of temperature, usually spoken of as following hemorrhage, was observed in only one case. There was a difference of 1 to 1.5° in the temperature range during the period of hemorrhage, which was from one to five days. In the case which died it required 48 hours for the temperature to drop from 102° to normal, when death occurred. The hemoglobin in one of the cases which recovered fell to 50 per cent.

Perforation was encountered in 7.1 per cent. of the cases. In four cases the diagnosis was confirmed by operation. Only two of the perforations occurred while the patients were in the hospital. In one of these the patient was moribund several days before the perforation occurred. In this case laparotomy was not performed nor could we secure an autopsy. The symptoms, however, were very characteristic. In two of those occurring outside the hospital the patients came to us with peritonitis and in a condition of collapse. These, I think, afford excellent examples of perforation occurring in walking typhoid fever, and will be described briefly.

C. J. White.—Male, age 26 years. First complained of malaise December 6, 1904, which continued until December 10, when a physician was first consulted. Bowels moved on December 11, and patient was doing fairly well until early December 13, when he was seized with severe abdominal pain, especially around the umbilicus. He was admitted to the hospital December 14 and operated on immediately. General peritonitis was found, with a perforation in the ileum about six inches from the cecum. The patient died 18 hours later. In this case the Widal reaction was positive.

The second case was very similar to the one just described, though the subject was but 10 years of age. At the time of entrance she was greatly shocked. This patient lived nine days after the operation, and was apparently doing well when it was observed that the pulse was beginning to flag. In spite of stimulants the patient died of cardiac asthenia a few hours later. At autopsy the peritonitis was found to have disappeared, complete drainage having been instituted. Autopsy also revealed six perforations with many ulcers, which microscopically showed typical typhoid changes.

The following is the case in which the perforation occurred while the patient was in the hospital:

C. B.—Colored, male, age 33 years. Was sent to the surgeon with the diagnosis of appendicitis. The history very much resembled one of recurrent appendicitis. In spite of the prominent symp-

toms of appendicitis and the negative Widal the diagnosis of typhoid fever was made. He remained in the hospital pursuing the course of a severe case, with attacks of abdominal pain occurring from time to time until the tenth day, when at 8 P. M. he was seized with a severe paroxysm, which partially subsided in 15 minutes. Blood examination at this time showed the leucocytes to be 8000 per c. m. The same number were found six hours later. The temperature increased somewhat, but in a few hours returned to the point it had registered two hours before the perforation. During the early morning hours he slept from two to three hours. Later in the morning symptoms of peritonitis were observed. Laparotomy was performed at 12 M., it being necessary to use but a small amount of ether. Peritonitis was found involving nearly the whole cavity. In the ileum about four inches from the ileo-cecal valve a perforation was found, having smooth edges, being about the size of a No. 22-caliber bullet. Perforation was sutured and the cavity drained. The patient's condition seemed excellent until 55 hours after the operation, when a change was noticed in the pulse.

*Death occurred 60 hours after the operation from cardiac asthenia.

The fifth case entered the hospital in a condition of collapse, with a history of two weeks' illness. He was operated upon and died five hours later. This patient came from a farm in Howard county, and was practically the first case from this community. The source of his infection could not be ascertained. While sick his quarters were on a small knoll above a spring, the excreta being thrown upon the hillside. He was admitted to the hospital on August 8. On August 31 a daughter of the farmer was admitted. On September 13 another daughter and two of the farm hands applied for admission. On October 2 the farmer's son and nephew were also admitted, while the grandmother of these children also suffered from the disease and died at home. Of the cases treated in the hospital all recovered except the one referred to above and the four-year-old child. The water was examined, but the organisms were not isolated. In studying the temperature of the cases of this series we found the usual course in the majority of the cases. In two instances it remained low throughout, though they were unmistakably cases of typhoid fever. The temperature in one case fell by crisis. In this case the average temperature during the first week in the hospital was 103°; during the second week 102°. At 6 P. M. of the fourteenth day the temperature registered 103°. At this time all the symptoms were marked. A gradual fall of temperature was observed until 9 A. M. the following morning, when it reached normal and there remained. The appetite at once returned, and all the symptoms disappeared in a few hours.

By far the most interesting case of the series is now to be described:

F. B.—Colored, female, age 24. Admitted to the hospital September 5 complaining with severe diarrhea, headache, high fever, etc. Four weeks previously she had been treated for typhoid fever. At the time of admission the general nutrition was good. The skin was moist and healthy, but the patient was very deaf; heart in good condition, pulse quick, but well sustained. At this time there were the physical signs of almost complete consolidation of the right lung, with beginning trouble in the left. The breath sounds were almost entirely absent in the right lung, with dullness and increased fremitus. Within a few days tubal breathing was heard, with rales and signs of resolution in the right lung. While this was taking place consolidation was progressing in the left lung, in which the process was repeated, but to a less degree. Thus there was what seemed to us to be a massive pneumonia of the right lung. Before leaving the hospital we found her lungs in good condition, all rales having disappeared. Her chart was characterized by enormous variations in temperature. At times the temperature would vary from 96° in the morning to 105° during the afternoon, and occasionally the variation exceeded this limit, e. g., on the fourth day is reached the astonishing figure of 9° in 3½ hours. It must not be thought that this remarkable range was of regular occurrence; on the contrary, it was especially characterized by extreme irregularity. Severe chills were observed during the course, but repeated examinations of the blood for malarial organisms and the sputum for the tubercle bacillus were negative. On the seventh day the temperature approached the normal, and except for a single rise to 102° occurring on the ninth day, it followed the normal line, giving promise to convalesce. By the morning of the twelfth, however, an upward trend was observed, and continued to rise steadily until two days later, when 104⅖° was observed. It then assumed the type of a continued fever, reaching normal again on the twenty-third day. Thus for

*The abdomen was soft and observed to move with each respiratory effort, peritonitis having disappeared.

11 days we were treating what seemed to us to be an unmistakable typhoid relapse. Two weeks later she was discharged in an apparently good condition. Three weeks from this time, however, she died suddenly of pulmonary hemorrhage. As an autopsy was not obtained, the origin of the hemorrhage was not definitely ascertained. It is interesting to know that at that time there were three other cases of typhoid in this family, one of which was treated in this hospital.

The study of the blood in typhoid fever is perhaps neither as interesting nor as helpful as in some other maladies. During the attack the red corpuscles were always subnormal, but at the time of discharge an improvement was usually noted. The white corpuscles averaged about 7500, many being as low as 4000 per c. m. We found, as many others have found, that it was not wise to be led too far by the leucocyte count alone, e. g., in the case of perforation cited above it was several hours before the slightest increase in the leucocytes was observed. In the case simulating appendicitis an increase of 6000 was found during the night. In another case, where the patient was suffering from great distention and pain, causing us to think strongly of perforation, the leucocytes were 19,000 per c. m. I do not think there is any doubt of this being one of those cases where local peritonitis occurs without perforation, which was the cause of death in one of our cases. The patient in question, however, was not operated upon and recovered. The hemoglobin, between 50 and 70 per cent. in one case, where there was no apparent hemorrhage, fell to 30 per cent. The patient recovered. The Widal continued absent in seven cases. Blood cultures were taken from the majority of the patients. By this means we were able to grow the bacilli from the circulation, and thus often make the diagnosis from 7 to 10 days before the Widal was present. In only one of our cases was another disease found associated with the typhoid. This was a young man who recovered from a severe attack of typhoid complicated with tertian malaria. Tuberculosis was encountered in two cases. The first was observed in a young man who at the time of admission presented the physical signs of a cavity at the right apex. During the course he had two very severe hemorrhages from the lung, but made a fair recovery and was living when we last heard from him a few weeks ago. The other case occurred in a young lady, aged 21, who was admitted to the hospital on the 6th of August. The disease followed the usual course, the temperature reaching normal in about four weeks. We then observed a slight evening rise, each subsequent rise being slightly higher than the former, until within a few days the 3 P. M. temperature reached 102⅕°. It was noticed that the patient was not gaining weight, notwithstanding that she was convalescent from her typhoid; and by the time her evening temperature had reached the figure quoted above our suspicions were, unfortunately, confirmed by the finding of the tubercle bacillus in the sputum.

Included in this series of cases is a very interesting one which I shall mention but briefly, as it has already been reported at a former meeting:

H. P.—White; male; aged 38 years. Entered the hospital on October 4, having been complaining with prodromal symptoms for the past two weeks. For the first few days, by the temperature and general condition of the patient, we looked upon it as a case of typhoid fever. Positive Widal was obtained on the second day. The leucocyte count was 10,000 per c. m. Within a few days he assumed a decided septic appearance, and the temperature was characterized by wide variations and extreme irregularity. At this time there was to be felt a definite mass in the epigastrium, and putting this together with his general condition and temperature, we suspected that he was also suffering from an abscess of the liver. Death ensued on the seventeenth day. An autopsy revealed no intestinal lesions whatever, but multiple abscess of the liver, from which we were able to obtain the bacillus typhosus in pure culture. It might be interesting to observe here that we employed these organisms in our laboratory for some time in making the Widal reactions.

The case of phlebitis, spoken of above, occurred in a white male aged 44 years, who suffered from an irregular but severe and protracted illness. The trouble occurred on the twenty-second day, when the temperature was averaging about 100°, practically no rise being observed at the onset of this condition. Pain was the most prominent symptom in this case, being very severe throughout the extremity. The internal saphenous vein of the right side was the seat of the inflammation. The edema at this time was very slight, but became very troublesome later. The patient made a slow but good recovery.

One orderly contracted the disease while working in a ward where there were 10 fever patients. The case was mild, however, and he made a good recovery.

The closing paragraph will be devoted to mortality: Eleven of the 70 cases proved fatal, a mortality of 15.7 per cent. This includes the two cases which entered the hospital for surgical treatment with general peritonitis. The following is a summary of the causes of death: Perforation, five cases; cardiac asthenia, three cases; hemorrhage, one case; liver abscess, one case; peritonitis without perforation, one case.

PERSONAL MENTION OF THE ALUMNI OF THE UNIVERSITY.

Under the above heading we propose to publish in the Bulletin personal notices of the Alumni of the University as they come to our attention. The object of the notice is to recall to the minds of old classmates the names of those who in years gone by were fellow-students and intimate associates. We trust that the alumni will take an interest in this column and will help to make it an attractive feature of the Bulletin.

Dr. W. T. Councilman of the class of 1878 is professor of pathology in Harvard University. Dr. Councilman has reached the highest position of distinction in his special line of work and has an international reputation.

Dr. I. S. Stone of the class of 1872 is a distinguished specialist in diseases of women in Washington, D. C., and an active fellow of the American Gynecological Association. Dr. Stone is one of the most industrious men in his profession and has a brilliant future before him in professional work. He is a warm friend of the University.

Dr. W. T. Howard, Jr., of the class of 1889 is professor of pathology in the Western Reserve University, Cleveland, Ohio. Dr. Howard has made a distinguished place for himself in his special line of work.

Dr. C. P. Noble of the class of 1884 is a distinguished specialist of diseases of women in Philadelphia. As surgeon to the Kensington Hospital Dr. Noble has done notable work both with his knife and pen. He is a most industrious author, and his contributions to literary medicine have been of exceptionable value.

Dr. Y. H. Bond of the class of 1867 is the dean of the Marion Sims' Medical College, St. Louis, Mo. Dr. Bond has done most valuable work in connection with that college and is recognized as one of the leading educators of the middle West.

Dr. J. W. Humrichouse of the class of 1873 is practicing his profession in Hagerstown, Md., with great success. There are few men better qualified for medical work and few have achieved greater local distinction than Dr. Humrichouse. Had he selected a larger field of work there is no position within the gift of the profession he could not have reached. He has all the accomplishments and all the gifts of the scholar and scientist.

Dr. W. S. Maxwell of the class of 1873 is a successful practitioner in Still Pond, Md. He is the same genial and noble-hearted fellow as when a student. Few men have done a larger practice in the country and more good for their fellowmen than Dr. Maxwell. He is the true type of the unselfish physician who has given the best years of his life to the people among whom he has lived. He has also been a most successful horticulturist, and what he does not know about the culture of fruits and flowers is not worth knowing. We almost envy a man of his habits and tastes, as he comes nearer to nature than is the privilege granted to ordinary men.

The annual meeting of the Medical and Chirurgical Faculty of Maryland will be held in Baltime April 25-27, 1905. The evening sessions, open to the public, will be held in McCoy Hall, J. H. U., at 8.30 o'clock. All of the addresses pertain to matters of interest to the public no less than to physicians. The opening session will be devoted to the presidential address by Dr. Edward N. Brush. Dr. Clarence J. Blake, professor of diseases of the ear in Harvard University, will open the Wednesday evening session with an address on "Co-operation in Medical Teaching," and this will be followed by three short papers illustrating the benefits conferred upon the community by medical science, Dr. Wm. H. Welch speaking on "Preventative Medicine," Dr. I. E. Atkinson on "Practical Therapeutics" and Dr. Robert W. Johnson on "Surgery." The annual oration will be given on Thursday at 4.30 P. M. in McCoy Hall by Dr. Wm. Osler, and will be followed by the annual dinner at the Stafford at 7 o'clock. The president will entertain the faculty Wednesday afternoon at the Sheppard and Enoch Pratt Hospital. Sessions will be held Wednesday and Thursday mornings, when papers will be read on general topics.

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EDITORIAL

TYPHOID FEVER AND MALARIA.—There is no doubt that a very large proportion of cases of typhoid fever is still mistaken and treated for malarial fever. This is especially the case in rural districts where skillful consultants and blood examinations are not readily obtainable. The occurrence of chills with great regularity is especially conducive to this error. The quinine is given in large and continuous doses, and, notwithstanding its failure to arrest the disease, it is continued in the hope that it may prove at last effective, until the patient's system is saturated with it. Even with so protean a disease as this a careful study of the case, even without the aid of the Widal reaction, should seldom leave doubt in the mind of the practitioner as to the real nature of the case. This becomes more positive where the quinine is found after a few doses to have no effect. In doubtful cases the disease is almost always typhoid. One should remember the fact that a case of typhoid always implies the existence of a previous case. In this climate malarial fever is only fatal in the congestive form, which is extremely rare with us. In this State the facilities afforded by the State and city bacteriological departments for the examination of the blood make it unpardonable in any physician not to give his patients and the community in which he lives the benefit of such opportunities for clinching the diagnosis.

CLINICAL RECORDS.—The medical student should be thoroughly impressed with the importance of keeping careful records of all interesting cases that come under his observation. It is a practice of the greatest utility, cultivating his powers of observation and teaching him to describe accurately what he sees. It also impresses upon his mind the pictures of diseases—many rare—with which he will meet in the times to come. Further than this, it provides the young practitioner with a mass of material to which he can often refer with advantage when in doubt, to see what his teachers have done under similar circumstances.

And taking a wider point of view: From the great Hippocrates, who drew up those admirable clinical records to be found in his "Books of the Epidemics," to the present time, medicine has been most advanced by the study and observation of nature herself. There have been men, indeed, like Bichat who asked no other guide. Each one of us can see for himself. Why, then, use only the eyes of others?

That greatest of American clinicians, Austin Flint, enumerated the following as the advantages to be derived from the record of cases: It improves the powers of observation and leads to the discovery of personal deficiencies in this regard which may be overcome. The ability to observe correctly is not a natural gift, nor does it accompany, as a matter of course, the acquisition of knowledge from reading or didactic lectures. It is an art to be acquired. It qualifies for describing with perspicacity the symptomatic phenomena in cases of disease. The ability to use language with accuracy and precision in simple description is not an innate faculty, but an acquirement.

It secures a more thorough study of cases in consequence of more concentrated and prolonged attention than the cases would be likely to receive were they not recorded, and in this way it has a favorable influence on the diagnosis and treatment. By inducing reflection and leading the practitioner to consult standard works with reference to points of inquiry which arise, it conduces in no small measure to professional improvement. Continued for a series of years it furnishes an accumulation of clinical experience which may be reviewed or referred to with great profit. The analytical study of cases which have been recorded may lead to results which contribute to an enlargement of the boundaries of medical knowledge.

SOCIETY OF ADJUNCT FACULTY.—A joint meeting of the senior and junior faculties of the medical department of the University of Maryland was held in the Law Building on the evening of March 16. The meeting was social in character and included a smoker. The

object of the meeting was to bring about a better understanding and a more united effort upon the part of the teaching bodies in the educational work of the University. Until quite recently the junior or adjunct faculty was without an organization of a distinctive character. As the corps of the clinical and associate professors, lecturers, demonstrators and chiefs of clinics is now made up of over 50 men who have various duties assigned to them in the way of instructing the student-body, their organization for conferences and for perfecting the different lines of work in which they are engaged must result in a wholesome influence over the senior faculty and over the students. The present system of instruction in the University is assuming larger and larger proportions from session to session. Important changes in the curriculum and in methods of teaching are becoming more and more necessary. All who are interested in the progress of the University fully realize the need of harmony and united action in the upbuilding of a great medical school. Progress is the order of the day in every department. This spirit of progress must take hold of every teacher if it is to extend to the student. Facilities for study must not only be presented to the student, but his interest in his work must be kept up by the enthusiasm of those who are instructing him. Moreover, as the junior faculty is composed almost entirely of young men of comparatively recent graduation, encouragement must be given them to follow lines of work and of original investigation which may add to the reputation of the University. The members of the faculty in charge of the business and educational interests of the University fully realize the responsibilities which rest on them, and may be relied on to do the best in their power, under existing conditions, for the future growth of the school.

University Esprit de Corps.—As is well known, the University of Maryland now has four well-organized departments, namely, the department of medicine, of law, of dentistry and of pharmacy. In these four departments there are over 800 students in attendance during the present session. In point of numbers this is the largest student-body connected with any institution in the State of Maryland. Whilst each department has an organization more or less independent of the others, there is a feeling among the student-bodies that they are closely related in some way at the University of Maryland as a whole rather than separated by departmental lines. Whilst this feeling is not as strong as it should be, a sentiment is growing that these student-bodies should come together in more concerted action for the good of the University. In no better way can the University spirit be promoted than through the organization of a strong athletic association. Men associated in athletic work have a common bond of union. This rule applies equally as well to the fraternities and to other student societies. It is important that all of these organizations of the student-bodies in the different departments of the University should be encouraged. They can be made to exercise a most useful influence in promoting a University *esprit de corps* by bringing the different departments into closer relations. The Bulletin hopes not only to be of service to the medical department, but it will stand for every movement that will advance the interests of the University in all of its departments.

Our Professors Emeritus.—Many of the older alumni of the University will recall with pleasure the men who filled the different chairs during their student days. Time has removed many of these old teachers from the field of active labor to that rest which belongs to the just, but two of the old members of the faculty are still associated with the present faculty as emeritus professors. We refer to Prof. G. W. Miltenberger and Prof. W. T. Howard, whose names will be recalled with pride by every old student who enjoys the privilege of having their names on his diploma. We are led to make these remarks by reason of the fact that on the 17th of March Professor Miltenberger celebrated his eighty-sixth birthday, and Professor Howard passed his eighty-fourth milestone in January last. Both of these old teachers, whilst venerable in years, are fresh in mind and vigorous in spirit. Their interest in the University has not ceased, and they still give dignity and confer honor upon the institution by having their names associated with the present faculty. The Bulletin extends to them the congratulations of all of the alumni and best of wishes for their continued good health and happiness. We may be pardoned for the suggestion that it would be a graceful act upon the part of the old students if, upon the occasion of their visits to the city, they would call and pay their respects to these old teachers. We need not say how welcome such a visit would be to these gentlemen in their retirement from the active

duties of professional life. The men of the present generation should not lose sight of the debt they owe those who have guided them in their early professional training. It is a rare privilege to meet with men who have been engaged in professional work for over 60 years.

Calvary Hall. — Many of the alumni of the University will recall the old Calvary Methodist Church which stands on the southeast corner of Greene and Lombard streets directly across from the University Building and Hospital. Some 30 or 35 years ago this church was one of the largest and most fashionable houses of worship in South Baltimore. The surrounding neighborhood was inhabited by many of the old and prominent families of the city. This section of the city has undergone great changes in recent years and is fast giving way to commercial purposes. Recently the congregation worshipping in Calvary Church moved out, and the church was purchased by the faculty of physic and will in future be used in the educational work of the University. For the present the basement will be used for the library and for the Young Men's Christian Association. The auditorium will be used for lectures, public meetings and for holding examinations. With the constant growth of the work of the University more and more room is required. The time is not far distant when it will become necessary to build additional laboratories and to provide larger facilities for the instruction of students. These improvements call for large expenditures of money, but it has been demonstrated that money judiciously expended in betterments of the plant will bring sufficient revenues to justify the outlay. Institutions of learning, like large railroad corporations, must extend their work or else cease to earn dividends. Notwithstanding the fact that the University has only a small endowment, under the present policy of the faculty it has acquired most valuable properties and is in a position to make progress in its educational work. Those at present in charge of its business interests believe that there is still room in our educational system for the unendowed school when conducted along proper business lines. Whilst the tax upon the teaching body is heavy and men are poorly paid in dollars and cents for their work, there is no scarcity of material either as respects quality or efficiency among those who take pride in educational work. This is shown by the large corps of young men who are engaged in different ways in giving instruction to medical students. The enthusiasm of these men is deserving of much praise, and those who persevere must realize that they are laying the very best foundation for professional success and eminence. No broader foundation can be laid for a wide and accurate knowledge of scientific and clinical medicine than in the laboratory, recitation room, hospital and dispensary. The man who best instructs others is instructing himself. He who does best what others do well has made the first step towards greatness.

Dr. Russell Murdoch.—The death of Dr. Russell Murdoch on the 19th of March from apoplexy cannot be allowed to pass without some notice from us. For whether we view his life from the points of citizenship, science, medicine or religion, we find that he possessed the highest qualities of human character. With a feminine gentleness, the utmost refinement of manner and a conscientiousness that sometimes seemed from its intensity to interfere with the most ordinary acts of life, he combined the utmost firmness of will. He was deeply religious, and that side of his character ever shone with brightness. He was neither unduly ostentatious in the display of his religious convictions nor did he shun the expression and exhibition of them to the world. He was well versed in literature and science and was an authority upon botany. In his profession he had acquired the distinction of a highly-skilled specialist, exhibiting a wonderful power for the invention of instruments, apparatus and operations.

After the Civil War, in which he held with great credit the position of surgeon in the Confederate army, he went abroad to perfect himself in his specialty. On his return he was made clinical lecturer on diseases of the eye and ear and placed in charge of this department in the Maryland University Hospital. Previously to that it had been attached to the chair of surgery. Dr. Murdoch was the first to treat it as a specialty and demonstrate the new methods which were coming into vogue through the influence of Von Graefe and others. He was a most attractive and enthusiastic lecturer, and it was a great disappointment to him to have to give up the chair to another at the close of the session of 1868-1869. It was no reflection upon him that a change was made; it was simply due to the fact that his successor was supposed to be able to exert a greater influence

in behalf of the school. Dr. Murdoch was in his sixty-seventh year.

Retrospective.—We may often recall the past with advantage if the examples and life it furnishes be helpful and inspiring. There are many bright spots in the corner of the school of medicine of our University which quickly come up before us and which the minds of our alumni may find pleasure from time to time in contemplating.

In the very earliest period, for instance, there was a man who taught, with all the earnestness of a realization of its truth and importance, the doctrine of an animate contagium. Read how John Crawford pointed out the sufficiency of this explanation of the cause of infectious diseases and showed how it throws light and precision over the darkness that prevailed regarding the origin of that large class of affections. A little later we can picture to ourselves the young anatomist, John D. Godman, thrilling his youthful audience with the magic of his eloquence in Anatomical Hall. The early introductories must have been occasions of great public interest when the citizens flocked to Chemical Hall to hear some distinguished professor dilate upon science or literature.

Among those most famous in this *rôle* the eloquent Irish chemist, De Butts, has been handed down with much éclat. Query: Might not these introductions be introduced again with profit? The period of the government of the trustees was one of the most brilliant in the history of the school. System and good business management characterized their control. Some great names appear in the faculty of that period, among whom Elisha Geddings, the great South Carolina savant, and Nathan R. Smith, our greatest surgeon, shine pre-eminent. Our connection with Ephraim McDowell through the honorary degree is pleasant to contemplate, showing that merit was appreciated by our predecessors. The making of dissections compulsory for the first time in America was one of the good deeds which we owe to the trustees. Then comes Power, fresh from the clinic of Louis, a most inspiring teacher of the doctrines of his master, and Laennce, and Bartlett, whose short stay was only atoned for by the succession of Power to his chair. Joseph Roby was an anatomist of anatomists, and helped to spread the fame of the school in the 40s and 50s. Christopher Johnston and William A. Hammond in the 50s made the microscope familiar and founded laboratory instruction among us. And then came the short two years of Charles Frick, that masterly investigator whose name we are trying to commemorate by the "Charles Frick Research Fund." And so we might go on with more recent events, but surely enough has been adduced to show that the past is rich in such reminiscences which should ever be held up before our young clinicians and investigators for their encouragement, imitation and guidance.

ABSTRACTS AND EXTRACTS

Gastroenterostomy.—At the meeting of the University Medical Society held on February 21 Prof. Randolph Winslow presented a man upon whom he had performed gastroenterostomy two weeks previously. The patient was 43 years of age and had been suffering with digestive troubles for several years. He had lost flesh, vomited at times, bowels acted with difficulty, and food taken one day could be washed out through the stomach tube the next day largely undigested, and pain and discomfort were felt in the epigastrium. He had been treated medically without relief, and came to the hospital for further treatment. His stomach was lavaged for several weeks, and he improved somewhat and was discharged. He returned in a few weeks as bad as ever, and was transferred to the surgical wards for operation. In addition to his digestive ailment his radial arteries were markedly sclerosed, and it was feared that he could not take an anesthetic safely, hence an attempt was made to operate under local anesthesia; but he complained so much that ether was administered, without either immediate or remote damage. A straight incision was made in the right rectus muscle and the peritoneal cavity exposed. The stomach was somewhat enlarged and displaced, and there were many adhesions about its pyloric end. The pylorus was contracted, apparently from cicatrization of a peptic ulcer. A posterior gastroenterostomy was done after the manner of Von Hacker, and the afferent and efferent limbs of the jejunum were also united by means of a Murphy button in order to avoid the "vicious circle" which is liable to occur when the bile passes into the stomach. The patient did absolutely well after the operation. He had no vomiting at all, no pain, and his bowels moved daily. He was propped up in a semisitting posture, which allows better drainage from the stomach than when the recum-

bent position is used. At the end of two weeks he is taking food freely, is walking around the ward and feels quite well. The button has not been passed, or at least has not been found in the stools, though it may have escaped notice.

Professor Winslow then made a historical review of the operation of gastroenterostomy. The operation was devised by Dr. Anton Woelfler in 1881 to sidetrack an inoperable pyloric cancer. He had intended to resect the pylorus, but finding the conditions prohibitive of this method, he drew up a loop of small intestine and attached it to the anterior surface of the stomach. The patient recovered and derived marked benefit from the operation. This method is known as anterior gastroenterostomy, and whilst it is capable at times of life-saving service, it has also disadvantages that materially limit its usefulness, persistent vomiting being one of the chief ill-effects. In order to overcome this tendency Dr. Victor von Hacker devised the operation of posterior gastroenterostomy. In this procedure the transverse mesocolon is found by raising the transverse colon, and is torn through in a non-vascular area, and the posterior wall of the stomach is pushed through the slit in the mesocolon. The jejunum is found at the point where it begins at the left side of the second lumbar vertebra. At a point about 10 inches from its beginning the jejunum is attached to the posterior surface of the stomach with two rows of sutures or a Murphy button. In spite of the attaching of the intestine to the posterior wall of the stomach, vomiting does frequently occur, and in order to overcome this symptom R. F. Wier advised and practiced the performance of an enteroenterostomy or the formation of an anastomosis between the entering and leaving loop of jejunum, thus allowing the bile and other secretions to pass directly into the efferent portion of the bowel without going into the stomach. Another modification of this method has been introduced by Fowler, who passes a No. 20 silver wire two or three times around the proximal loop sufficiently tight to occlude the lumen of the gut without causing strangulation. This absolutely prevents the passage of bile into the stomach through the duodenal end of the anastomosis. To be still more certain that this object is attained, W. J. Mayo cuts the afferent loop entirely across in some cases and invaginates the divided ends, but, as he says, "This is too much of an operation." The Roux or Y operation secures the same result by dividing the jejunum and implanting the distal end into the stomach and anastomosing the proximal end with the descending loop. The safest method of performing gastroenterostomy is with the elastic ligature as devised by McGraw. The intestine and stomach are brought into relation with each other and united with a posterior row of sutures, and then a large needle threaded with an elastic ligature drawn taut is passed through the stomach and intestinal walls and is tightly tied. The row of sutures on the posterior surface is now continued so as to inclose the elastic suture entirely. There can be no leakage in this method, and in a few days the elastic ligature cuts out and falls into the intestine, leaving a free opening between the stomach and the intestine. Of course, where it is necessary to feed the patient at once, this method is not applicable.

The operation of gastroenterostomy is performed for the relief of both malignant and non-malignant stenosis of the pylorus. In the case of malignant disease it is simply a palliative procedure, and whilst it prolongs life, the patient succumbs usually in a short time. In non-malignant stenosis the relief is permanent and the patient is restored to a comfortable and useful life. In many cases of ulcer of the stomach, with vomiting, pain and frequent hemorrhages, gastroenterostomy is the best method of treatment, and should be performed before the vitality of the patient has been too much sapped. The results in such cases are often brilliant, whilst the mortality is not great. In malignant disease of the pylorus the mortality is much greater, as these patients are usually not transferred to the surgeon until they are in an advanced stage of exhaustion.

As to the method of choice, surgeons differ in their preferences, but when celerity is desired the anterior gastroenterostomy with a Murphy button has many advantages. When time is not such an important factor posterior gastroenterostomy with the suture method and a very free opening is to be preferred.

THE ADVANCES IN THE PHYSIOLOGY AND PATHOLOGY OF THE PANCREAS AND THEIR APPLICATION TO THE DIAGNOSIS OF PANCREATIC DISEASES.—Dr. John C. Hemmeter in *American Medicine,* March 11, has an exhaustive article with the above title, from which we abstract the following: To be of use pathological records should give the objective and subjective symptoms, chemical and microscopical analyses of feces, urine, blood and gastric contents after ingestion of weighed amount of ingesta, and findings at oper-

ation or autopsy. Intestinal digestion is not all due to bacteria; the colon contents when sterilized still contain active enzymes. The erepsin of Colnheim may fill the rôle of the pancreatic juice as soon as the albumin molecule has been broken either by the latter or the gastric juice. H. reports a case of partial autolysis of the pancreatic glandular apparatus, the islands of Langerhans appearing intact. We do not yet know enough of the internal secretion of the pancreas to justify us in assuming a causal relation between disease of these islands and diabetes. The prospect of determining relative pancreatic insufficiency by examining the nitrogenous, starchy and fatty remains of the ingesta was not regarded as hopeful. The determination of the total nitrogen in the feces as a gauge for defective proteolysis involves the difficulty of confounding imperfect meat digestion with defective absorption. The feces may show no traces of undigested meat fibers, and yet may contain nitrogen equal to 10 to 13.5 per cent. of the weight of the dry feces. The method of Adolph Schmidt is more promising. This is based on the fact that only gastric juice can digest connective tissue and only pancreatic juice nuclear substance of meat fiber.

In cases of heterochylia first described by H. in 1897, and characterized by large variations of HCl, pepsin and rennet in the gastric juice in the same individual, undigested and connective tissue fibers were found in the feces only during absence of elements of gastric juice, whereas when there was hyperchloridia none were discernible. In the former case likewise the fibers disappeared when HCl was administered; also in two cases of compression and stenosis of the duct of Wirsung, respectively, H. found in the stools muscle fibers showing well-preserved nuclei.

Ciliary Nerve Theory of Sympathetic Opthalmitis. — Dr. S. Theobald (1867) says that when we turn from the germ theory to this discredited nerve theory we no longer find discordance, but the completest harmony between theory and fact. The absence of bacteria in the exciting eye; the variable period of incubation; the significance of disease and injuries involving the iris and ciliary body—those structures so richly supplied with sensory nerves and inflammation of which almost always means intense suffering—the site at which the inflammation commonly begins in the sympathizing eye; the occurrence of sympathetic disease in consequence of non-penetrating injuries of the cornea, which, however, have given rise to painful and protracted keratitis; the arrest or favorable modification of the disease from enucleation of the primarily affected eye; its occasional development after enucleation of the exciting eye; the long-continued existence of sympathetic irritation, in some cases without the development of actual inflammation and in others the occurrence of inflammation with but little precedent irritation—all these phenomena become explicable; are, indeed, but what the theory would lead us to expect.—*Jl. Am. Med. Asso.,* Jan. 28.

The Apparent Increase of Pneumonia.—Dr. John S. Fulton in the *Journal of the American Medical Association,* January 14, 1905, finds no proof in statistics that lobar pneumonia has grown more prevalent or fatal at any period of life, with the possible exception of children under five. The disease was formerly less frequently reported than now because it was so often masked in childhood and old age. The acute respiratory diseases of children were in former years commonly mistaken for affections of the nervous system.

The Abuse of Purgation Before and After Operation.—Dr. I. S. Stone, of Washington, D. C., surgeon to Columbia Hospital, in an article on the above subject, *American Medicine,* February 25, concludes that excessive purgation should be restricted because it is enervating to the general system. It produces great irritation to the nervous lining of the bowel. It may add to some of the dangers we are most anxious to avoid—ileus and paresis. Purgatives have very little effect in limiting the amount of extra-peritoneal exudate and fluids. Instead of calomel and saline purgation, bland evacuants, such as castor oil, should be used before abdominal section. The use of bland non-fermentative foods is desirable until just before operation in weak patients. After operation limit peristalsis; give only small quantities of food and drink by mouth. Rarely give opium. Enemas should be administered to relieve distention and cause peristalsis in downward direction. After normal peristalsis laxatives should be given as required.

Origin of Adenomyoma of Uterus.—J. Whitridge Williams (M.D., 1888), before the Southern Surgical and Gynecological Association (*Journal of American Medical Association,* January 7), described a uterus removed at autopsy from a woman who died from hemorrhage from placenta

previa. The area of placental attachment covered two-thirds of the anterior of the uterus. On section, after hardening, numerous irregularly-shaped, more or less oval, areas of a dull white appearance, and varying from a millimeter in diameter to structures 5x10 m. m. in their various dimensions, could be seen throughout the entire thickness of the uterine walls, which measured three c. m. in their thickest parts. These areas were most abundant immediately beneath the endometrium, but could be traced outward through the entire thickness of the uterine wall to its peritoneal covering. Microscopically they were found to consist of typical decidual tissue made up of characteristic decidual cells and glandular spaces lined by cuboidal epithelium. So far as ascertainable, this is the first case in which such a distribution of decidual tissue was observed. While the vast majority of such growths are clearly derived from Muellerian tissue, conclusive evidence against the Wolffian origin of certain cases has not yet been and probably never can be adduced.

BOOK REVIEWS

Post-Mortem Pathology. Henry W. Cattell, A.M., M.D. (Second and Revised Edition.) 1905.

This book has been written for those who ought to make autopsies, but do not, and for those for whom such investigations are required. In his preface to the first edition the author calls attention to the well-recognized fact that the physician who improves his opportunities for pathological study on the cadaver will be a better diagnostician and a safer therapist; will have a more enduring reputation and will receive a greater pecuniary reward than he who neglects such means of investigating morbid processes.

The author has done his work well, and has presented us with one of the most complete, if not the most complete, textbooks on the subject in the English language.

The opening chapter will be of great benefit to anyone contemplating the construction of a modern post-mortem room; the drawings and descriptions of suitable tables, icebox, lighting and water appliances are given in detail.

In describing the methods and order of examination nothing is taken for granted, so that one may follow the directions and working independently with satisfactory results. The author gives numerous illustrations of the various methods pursued in opening the various cavities and the proper incisions into the different organs. These illustrations are extremely well done, and in our opinion are the most valuable part of the work. After describing the methods of opening the cavities attention is directed to the diseases of the organs contained therein, so that one may keep in mind the lesions which are apt to be found; for example, in case of the abdominal cavity, the pathological conditions of the spleen, stomach and intestines, kidneys and adnexa are noted in some detail. The same method is followed in the thoracic cavity and the brain and spinal cord. An interesting chapter on post-mortem examinations of the new-born, as well as one of comparative post-mortems, adds to the value of the book.

The Prussian regulations for the performance of autopsies in medico-legal cases is valuable to one doing medico-legal work. The reviewer has called attention to merely a few of the chapters. Each of the 27 contained in the book is replete with timely and helpful suggestions, and we take great pleasure in recommending Cattell's work to anyone interested in the subject. J. L. H.

Diseases of the Liver, Gall-Bladder and Bile Ducts. By H. D. Rolleston, M.A., M.D. (Cantab.), F.R.C.P., Physician to St. George's Hospital, London, etc. Philadelphia, New York and London: W. B. Saunders & Co. 1905.

This bulky octavo of 794 pages, 7 plates, and 97 figures, deals with subjects of intense interest. Dr. Rolleston is fully qualified to write such a book, having paid especial attention to both the clinical and pathological sides of these affections for the past 12 years and published numerous observations upon them. He very wisely excludes the nominal anatomy and physiology of the parts discussed, referring his readers therefor to the textbooks. It is interesting to note that "functional disease of the liver" occupies only seven pages. At p. 5 "foaming liver" is described—a terminal infection which was shown by Welch and Nuttall in 1892 to be due to the bacillus aerogenes capsulatus. The liver is the organ most frequently affected by this organism—15 of 23 cases tabulated by Pakes and Bryant. The effects of tight lacing are described on pp. 8-15. Men may be affected in the same way by a tight belt or strap. With regard to the *rôle* of alcohol in cirrhosis, we are told that its importance has been made rather too much of. *Per se*, it has not specific effect except fatty degeneration. "It gives rise to cirrhosis in a secondary manner either by

leading to the production of scleroginic poisons or by enabling such poisons to have full sway on the liver." In only a few instances when alcohol was introduced in animals for experimental purposes has cirrhosis resulted. Pp. 300-304 are devoted to "pigmentary cirrhosis of hemochromatosis," of which only five cases have been described in America and three in England. We learn (p. 365) that the use of iodide of potassium in tertiary syphilis was first discovered in 1831 by Dr. R. Williams of St. Thomas' Hospital. There is no such thing as "hematognous" jaundice. It is always obstructive—gross, as pressure, or minute, from inflammation of small intrahepatic ducts from poisons derived from the blood circulating through the liver. The author does not think we are yet justified in assuming that acute yellow atrophy and phosphorus poisoning are identical (p. 568). We could not understand the entry "Washing as a symptom of chlorosis" in the index (p. 794) until we referred to p. 229, and found it should be "wasting." Almost all the illustrations are original. The author has ransacked medical literature in compiling this work, which seems to contain about everything of importance upon the subjects treated. We were much struck with the very prominent part taken by Baltimore pathologists and clinicians in the development of these diseases.

Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine. By William Osler, M.D., F.R.S., Professor of Medicine, Johns Hopkins University. Philadelphia: P. Blakiston's Son & Co. 1904.

This collection of Dr. Osler's lighter and festive productions is worthily dedicated to Dr. Daniel C. Gilman "in memory of those happy days of 1889, when, under your guidance, the Johns Hopkins Hospital was organized and opened, and in grateful recognition of your active and intelligent interest in medical education." The 18 addresses, commencing with "Aequanimitas" and ending with "The Master Word," and ranging over the entire field of medicine, evidently represent what the author regards as the best of his literary work, and as such offer a treat to men of culture, especially of our own profession. Most of them are already familiar to us, but they bear reading and rereading, for they are destined to take rank among us as medical classics. One cannot rise from their perusal without a feeling of betterment, such inspiring and satisfying pabulum do they offer to the yearnings of the hungry human soul. Among their merits one readily recognizes a simple and transparent style, a wonderful knowledge of books and human nature and great common sense. Some men are good teachers; their tongues utter the words of wisdom and good counsel, but, alas! their life and character do not always correspond. The lessons which this book teaches come with the added impress of a boundless humanity, the loftiest ideals and a blameless life.

E. F. C.

Ninth Annual Report of Board of Managers of the Springfield State Hospital of the State of Maryland. Pp. 61. Balto., 1905.

The superintendent, Dr. J. Clement Clark, says that more patients were admitted during the year ending September 30, 1904, than in any previous year, the number being 116 males and 80 females. The total number under treatment was 706, and 605 of these remained in hospital at the close of the year. There were 36 recoveries and 8 improved; 50 died. The most frequent form of mental disease was dementia, followed by imbecility, epilepsy, paranoia and general paresis; 22 per cent. were traceable to heredity. An epidemic of typhoid fever occurred in October, there being nine cases. There were three more cases during the summer. The source of these cases could not be ascertained. The use of the bromides has been abandoned in the epileptic colony, continued use of these agents being regarded as harmful by producing dementia. Under other treatment—normal alkaline salts, adrenal gland, etc., with amyl nitrite and hyoscine hydrobromate for series of attacks—the mental and physical condition has markedly improved. The first commencement of the Training School for Nurses was held with four graduates, two male and two female. The course is of two years, didactic and clinical.

E. F. C.

The figures of the examination held by the Board of Medical Examiners of Maryland, December 14-17, 1904, show that of the 43 applicants there were 14 who participated in the examination for the first time, of whom eight were successful. There were 2 University of Maryland men in this group, of whom one got only 60⅔, while the other passed with 79. There were 29 applying for re-examination in branches in which they had previously failed, of whom four were successful in working off all branches. Seven of the 29 were University of Maryland men, of whom three were successful.

NOTES AND ITEMS

THE following-named physicians have been recent visitors to the University Hospital:

Dr. J. M. Josey (class 1904), Lamar, S. C.
Dr. B. F. McMillan (1882), Red Spring, N. C.
Dr. T. A. Mann (1903), Durham, N. C.
Dr. T. W. Clark, Quarantine Hospital, Baltimore.
Dr. C. W. Heffinger, Sykesville, Md.
Dr. C. W. Gentry (1903), Puoree, S. C.
Dr. J. O. Purvis (1905), Annapolis, Md.
Dr. Frank H. Thompson (1889), Annapolis, Md.
Dr. W. T. Sappington, Webster Mills, Pa.
Dr. D. A. Watkins (1905), Hagerstown, Md.
Dr. W. S. Seymour, Trappe, Md.
Dr. H. D. Walker (1902), Elizabeth City, N. C.
Dr. W. G. Harrison (1892), Talladega, Ala.
Dr. D. B. Sprecker, Sykesville, Md.
Dr. J. C. Johnson, Atlanta, Ga.
Dr. L. C. Carrico (1885), Bryantown, Md.
Dr. H. H. Flood, Skien, Norway.
Dr. C. K. Foutz, Westminster, Md.
Dr. F. W. Weed, U. S. A. (1903), Philippine Islands.

DR. GEORGE L. WILKENS (1870) was married to Miss Annie Beattin of Philadelphia March 28.

DR. J. CLEMENT CLARK sailed for Liverpool March 29. He will remain abroad until the end of May, and will study the hospitals for the insane in England, Scotland and Germany.

WEST VIRGINIA EXAMINATIONS, 1904.—The following graduates of the University passed: April (1900) 87, July (1901) 80, (1903) 90, (1904) four reached 86; November (1902) 94, (1904) 91. These were among the highest grades reached.

DRS. ISAAC R. TRIMBLE and WM. H. NOBLE have been elected surgeons on the Cambridge (Md.) Hospital staff, and Dr. Lewis M. Allen, obstetrician.

DR. SAMUEL L. FRANK was re-elected president of the Hebrew Hospital and Asylum Association of Baltimore.

DR. EDWARD E. MACKENZIE was elected attending physician to the Baltimore General Dispensary on January 12.

DR. WM. H. BALTZELL is spending a time in Egypt.

DR. CHARLES P. NOBLE (1884) has been elected consulting surgeon on the staff of the Jewish Hospital, Philadelphia.

DR. WILLIAM H. NOBLE, M.D. (1883), was chosen by the trustees physician in charge of the Western Maryland Hospital at Cumberland, Md., March 9. He practiced after graduation at Port Deposit, Md., and more recently for some years in Philadelphia.

DR. DANIEL ST. THOMAS R. JENIFER (1904) of Long Island, near Towson, Baltimore county, Maryland, has settled for practice at Atlantic City.

DR. WIRT A. DUVALL (1888) has been appointed assistant surgeon of the Fourth Regiment Infantry, Maryland National Guard.

DISPENSARY PHYSICIANS, 1904-1905.

DR. JOHN HOUFF, Disp. Phys.

DEPARTMENT

STOMACH—Dr. J. H. Iglehart, Chief of Clinic.
Dr. R. A. Warner, Assistant.

SKIN—Dr. J. R. Abercrombie, Chief of Clinic.

THROAT AND NOSE—Dr. W. E. McClanahan, Chief of Clinic.
Dr. R. H. Johnston, Assistant.

CHILDREN—Dr. H. C. Hyde, Chief of Clinic.
Dr. J. M. B. West, Chief of Clinic.

WOMEN—Dr. W. K. White, Chief of Clinic.
Dr. F. J. Wilkens, Assistant.

GENITO-URINARY—Dr. P. Edmunds, Chief of Clinic.
Dr. J. Emerich, Assistant.

NERVOUS—Dr. Chas. W. McElfresh, Chief of Clinic.
Dr. Frank O. Miller, Assistant.

MEDICAL—Dr. G. Wilson, Chief of Clinic.
Dr. G. C. Lockard, Assistant.
Dr. H. J. Maldeis, Assistant.
Dr. Geo. S. Kieffer, Assistant.
Dr. I. J. Spear, Assistant

SURGICAL—Dr. John G. Jay, Chief of Clinic.
Dr. M. J. Cromwell, Assistant.
Dr. O. P. Penning, Assistant.
Dr. J. A. Tompkins, Assistant.
Dr. N. Winslow, Assistant.
Dr. F. Adams, Assistant

DISPENSARY REPORT.

From April 1st, 1904, to April 1st, 1905.

DEPARTMENT	NEW CASES	OLD CASES	TOTAL
1—Medical	1,110	5,391	6,501
2—Surgical	1,255	4,231	5,486
3—Nervous	335	3,011	3,346
4—Genito-Urinary	683	2,463	3,146
5—Throat and Nose	577	1,468	2,045
6—Women	775	1,076	1,851
7—Skin	547	1,107	1,654
8—Eye and Ear	670	977	1,647
9—Children	579	807	1,386
10—Stomach	213	875	1,088
Grand total	6,744	21,406	28,150

Number cases treated in 1904-05 28,150
Number cases treated in 1903-04 24,746

Increase over 1903-04 3,404

JOHN HOUFF, M.D.,
Dispensary Physician.

THE HOSPITAL BULLETIN

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A CASE OF OVARIAN TUMOR OF FORTY-TWO YEARS' STANDING, FROM WHICH 211 2¼ GALLONS OF FLUID WERE REMOVED BY 269 TAPPINGS—OVARIOTOMY—RECOVERY.

By T. A. ASHBY, M.D.,
Professor of Diseases of Women, University of Maryland.

The following case presents a number of points of interest and is worthy of record from three points of view: First, the long period of invalidism from a curable disease; second, the endurance of the patient under a most distressing affliction; third, the value of surgery in dealing with apparently incurable conditions.

The history of the case has been kept by the patient, a very intelligent woman, and has been prepared for me by Dr. C. F. Miller of North East, Md., who has taken great pains to verify the facts. The dates of the numerous tappings and the amount of fluid removed each time were carefully recorded by the patient and her husband. The amount of fluid removed each time was carefully measured and is as accurate as such measurement can be made. Making allowances for small errors, the sum total is large enough to create astonishment that any individual should survive such a drainage upon her vitality.

The patient, Mrs. M., applied to Dr. J. L. Atlee of Lancaster, Pa., for treatment for an intra-abdominal tumor in November, 1861. Dr. Atlee diagnosed an ascites, tapped the abdomen and removed 32 pints of fluid. This gave relief, and there was no return of the fluid for one year. In 1862 a second tapping became necessary, and four gallons of fluid were withdrawn. From 1862 until 1868 yearly tappings were made, and an average of 32 pints of fluid were removed each time. From 1868 to 1876, a period of nine years, there was no accumulation of fluid in the abdomen, but from the latter year until March 11, 1885, yearly tappings were necessary. In 1880 Dr. Atlee advised an ovariotomy and the patient went to him for the operation, which, upon a more careful examination, he declined to do, and continued to tap the abdomen. From March 11, 1885, the accumulations of fluid became more rapid, and it became necessary to tap her during the months of May, July, September and November of that year. During the year 1886 she was tapped nine times, and the following year 11 tappings were made. During the year 1888 13 tappings were necessary, and from that year until 1895 she was tapped 88 times. During the year 1895 18 tappings were made, and from that year until 1903 the tappings became necessary every three or four weeks. The patient's vitality had now become so lowered by these repeated tappings that her physician, Dr. Miller, advised an ovariotomy as the only hope of saving her life. The patient assented to an operation and was brought to me by Dr. Miller on November 10, 1903, for treatment. On the following day, November 11, I did an ovariotomy and removed a large ovarian cyst. The operation presented a number of difficulties, but they were overcome and the sac was removed as a whole by dissecting out a large section of the abdominal wall to which it was firmly attached. Owing to the repeated introductions of the trocar through the wall of the abdomen to withdraw the fluid the cyst had grown firmly to the wall over a surface four by six inches in area. The wall of the abdomen and of the sac at this place was two and a-half inches thick. It was necessary to remove an elliptical section of the abdominal wall eight by five inches in order to remove the sac. As there was the greatest abundance of tissue from the overdistended wall of the abdomen, no difficulty was experienced in removing this large section. The pedicle attaching the tumor to the uterus was very small and the sac was easily detached after the abdominal wall was cut away. The tumor had been nourished through its attachment to the abdominal wall. There were no adhesions at any other point, and but for the repeated tappings at no time during the 42 years of invalidism would an ovariotomy have been attended with any difficulties. In addition to the ovarian tumor, I found

when the abdomen was opened that the patient had a general miliary tuberculosis of the peritoneum. All over the intestinal and parietal peritoneum there were deposits of small tubercles and a widespread infection. The ovarian sac was also covered, and it is my opinion that the infection took place through the repeated tappings. This condition of the peritoneum gave me grave apprehensions of subsequent trouble from the tubercular deposit. The patient bore the operation without shock and made a very rapid recovery. At no time did she show the least signs of trouble. She was able to return home within three weeks' time. I requested Dr. Miller to keep me informed as to the subsequent history of this case. The patient had removed to Pennsylvania and was not heard from for some 11 months. In October, 1904, Dr. Miller wrote me that his patient had developed a tumor in her left breast which he desired me to remove. The patient again returned to the University Hospital, and I removed the entire breast. Her general health had so improved since the ovariotomy of the previous year that I scarcely recognized her. She had gained over 20 pounds in flesh and was perfectly well, if the condition of her breast be excluded. She remarked to me that she had had one year of good health for the first time in 42 years. The tubercular condition of the peritoneum had entirely disappeared. A cure had been effected through the removal of the ovarian sac. The cure of the tubercular peritonitis by the removal of the ovarian cyst proves most positively the origin of the tubercular deposits on the peritoneum and raises the question as to the duration of this deposit. In addition to the fluid contents of the cyst there was undoubtedly a large accumulation of ascitic fluid in the general abdominal cavity which was removed from time to time in connection with the repeated tappings of the abdomen. There is no way of determining how long the tubercular infection had existed and what part it played in the rapid accumulation of fluid in the cyst and abdominal cavity. Dr. Miller thinks that when Dr. Atlee first examined the case in 1861 he came to the conclusion that it was not a tumor, but a general peritoneal dropsy. I will quote from Dr. Miller's letter the history of this singular case:

"The first tapping was done in November, 1861, by Atlee; the last on November 7, 1903, by Miller, with 267 intermediate tappings by Drs. Atlee, Pense, Hay, Amoss and Miller. Atlee thought he was tapping a large cyst, and in 1880 advised an operation, at which time she went to be operated on, but after making a thorough examination concluded not to operate, but to continue on tapping, as her general health was not very good at that time. He never gave a definite answer why he did not operate, more than he thought it would be better to continue on tapping as before. My opinion is that when he examined her carefully he came to the conclusion that it was not a tumor, but general peritoneal dropsy he was dealing with. This tumor was only recognized about nine or ten years ago by myself, and it then had the appearance of four or five tumors connected together. The following are the dates of the birth of her seven children: First, November 6, 1859; second, August 5, 1865; third, August 12, 1867; fourth, June 4, 1870; fifth, February 17, 1872; sixth, August 5, 1873; seventh and last, February 26, 1876. She reached the menopause at 41, and again commenced to menstruate regularly at 60 until operated on. It is likely ascites developed with pregnancy the first time, although not recognized until she had gotten up from childbed, when she was almost as large as before confinement. During the second and third pregnancies ascites disappeared throughout the nine months to return after delivery. She was tapped 11 months after the third child was born, when the ascites disappeared and did not reappear until after her seventh child was born, a period of almost nine years, when it returned and kept on increasing regularly for 23 years, when the tumor began to grow more rapidly and the ascites diminished some until the last tapping, November 7, 1903. The amount of fluid drained from her was 2112¼ gallons, or 33 hogsheads, 1 barrel and 1¼ gallons."

The tappings number 269. The first 17 tappings were done by Dr. Atlee. It will be admitted that the record here given is a remarkable one, and admitting that some errors have been made in the observation kept, the number of tappings and the amount of fluid removed exceeds by far that of any case I have been able to find recorded. The nearest approach to this case is that of a woman reported by Bland Sutton, who at the age of 26 years was tapped for the first time, and during the next 26 years was tapped 80 times, and was relieved in the different tappings of 6631 pints of fluid, or of more than 13 hogsheads.

The points of greatest interest are found in the remarkable endurance of the patient under such conditions and the ease with which a cure was effected after 42 years of invalidism.

LIGATION OF ABDOMINAL AORTA FOR GUNSHOT WOUND.

By W. D. Scott, M.D.,
Resident Surgeon, University Hospital, Baltimore, Md.

Before presenting an account of our case, which, so far as I am able to ascertain, is first reported upon our records, when operation was done, and after a careful review of ancient and recent medical literature, is a second recorded report of ligation of abdominal aorta for gunshot wound. This seems pertinent, since the operation is employed as the last expedient, to make a brief resumé of the evolution of the operation, its indications, regional anatomy of, methods of operation, results obtained up to the present time, etc. Doubtless everyone is familiar with the heavy mortality following this very unusual operation. No case has ever been reported of the abdominal aorta being tied successfully. But this is not surprising, as the operation is indicated only in certain cases of aneurism which have burst or have resisted all other treatment and for the arrest of primary hemorrhage. Fifteen reported operations with 15 deaths too vividly express the danger of this operation as performed by our present method. Reasoning from analogy, the mortality reported should not necessarily follow, as the re-establishment of the circulation after operation has been proven, since numerous investigators have successfully ligated the aorta in some of the lower animals, and in one case to be mentioned a femoral pulse was noted nine hours after operation. The reports of Billroth's clinic contain the history of a case of occlusion of abdominal aorta where collateral circulation was fully adequate to maintain the integrity of the parts below. In this case the internal mammary, with its anastomosing branches, was found at autopsy to be enormously increased in size. Again, since the majority of these operations were performed prior to the perfection of our modern surgical technique and suture material, and since one case, that of Keen's, lived 48 days after operation, it may reasonably be urged that the operation should not entirely be abandoned, regardless of its past and present high mortality. The most favorable situation for application of ligation is some point below the origin of the inferior mesenteric artery, which arises from the aorta one-half inch above its bifurcation, a point a little to the left of the spine and opposite the lower border of the fourth lumbar vertebra, or represented externally by a point about one-third c. m. (1½ inches) below and a little to the left of the umbilicus, and, more accurately, by a line crossing the abdomen on a level with the highest points of the iliac crests. Within these limits all of the branches of the abdominal aorta are saved except the lumbar, common iliac, and median sacral, and somewhat important is the fact that here the artery is covered only by peritoneum. Collateral circulation here would be maintained by anastomosis between the superior epigastric (a branch of the internal mammary which arises from the subclavian above) with the deep epigastric below (a branch from external iliac). Possibly by the lumbar arteries above, with the ilio-lumbar, a branch of the posterior trunk of the internal iliac, and the circumflex iliac, a branch of the femoral below. And, if above the interior mesenteric, by anastomosis between the superior mesenteric above with the inferior mesenteric below.

As to the methods of operation, there are two—transperitoneal and retroperitoneal.

Transperitoneal Method. — Landmarks — Median, vertical abdominal lines; transverse line on level with highest iliac crests. Make an incision about 10 c. m. (4 inches) in length in linea alba, with its center corresponding to the umbilicus, the incision passing slightly to the left of navel to avoid the round ligament of the liver and the urachus. The peritoneal cavity having been opened, the small intestines and mesentery are retracted upward and to the sides. Artery is located by its known position and pulsation; peritoneum covering vessel below the inferior mesenteric is carefully divided and artery cleared, carefully avoiding the inclusion of the sympathetic nerve fibers, namely, nerve cords from the aorta plexus (lying along aorta between the superior and inferior mesenteric arteries) to the hypogastric plexus (lying between the common iliacs). A flat ligature should be used, and the needle passed away from the inferior vena cava. Keen has devised an instrument for temporary compression of the vessel, which is applied directly to the aorta after abdominal incision, thus avoiding injury to the intestines.

Retroperitoneal Method. — Here the artery is approached from the antero-lateral abdominal region. Make an incision on left side from the apex of the tenth rib downward and forward to within about one inch of the anterior superior spine of the ilium. Divide the tissues down to the peritoneum. Patient is tilted over on sound side, peritoneum is dissected away and pushed back from the iliac vessels, and aorta exposed and ligated.

By this method ligation is more difficult and the danger of including the sympathetic nerve fibers is increased.

To Sir A. Cooper is due the honor of being the first to ligate the aorta, in 1817, and his initial operation has suffered little change in the lapse of nearly a century. One cannot fail to respect and venerate the genius whose master mind first conceived and whose hand was the first to carry out the determination to ligate the abdominal aorta, and who, guided by pathological observation and physiological experiment, arrested the current of blood in the largest vessel in the body, trusting to the collateral circulation for the maintenance of vitality of the parts suddenly deprived of blood.

Following is the report of collected cases:

Name.	Sex.	Age.	Date.	Diagnosis.	Route.	Result.
Sir A. Cooper.	M	38	1817	Diffused Inguinal Aneurism.	Trans-peritoneal.	Death in 48 hours.
James.	M	44	1829	Ext. Iliac Aneurism.	Distal ligation first and peritoneal opened.	Death in few hours.
Murray.	M		1834	Inguinal Aneurism.	Retro-peritoneal.	Death in 24 hours.
Monterio.	M		1842	Diffused Inguinal Aneurism.	Retro-peritoneal.	Death on 10th day.
South.	M		1856	Common Iliac Aneurism.	Retro-peritoneal.	Death in 43 hours.
H. McGuire.	M		1868	Aneurism of lower part of aorta, both common iliacs and left external iliac.	Retro-peritoneal.	Death in 12 hours.
Stokes.						Death.
Watson.						Death.
Czerny, of Vienna.						Death.
Keen.			1902	Aneurism.		Death in 48 days.
....				Wound of aorta.		Death.
.....				Wound of femoral.		Death.
H. Milton, of Cairo, Egypt	M	45	1890	Aneurism of lower aorta.	Trans-peritoneal.	Death in 24 hours.

In Sir A. Cooper's case the inguinal aneurism had burst and the aorta was tied about three-quarters of an inch above its bifurcation by the transperitoneal or Cooper's method. Patient died from acute peritonitis in 40 hours.

James of Exeter ligated the aorta, as Cooper did, upon a case in which he had previously done the distal operation for inguinal aneurism, but patient died speedily.

Murray at Cape of Good Hope employed the retroperitoneal route which bears his name, and tied vessel three to five lines above its bifurcation. Patient died in 23 hours.

Monteiro at Rio Janeiro ligated aorta by Murray's method for a large false aneurism in the lower and right side of the abdomen. Patient died on the tenth day from secondary hemorrhage.

Hunter McGuire's case was an aneurismal tumor, goose-egg sized, in the left iliac region. He attempted digital pressure near the umbilicus, but failed. He first contemplated ligation of the left common iliac artery, but finding the disease more extensive than he had anticipated, he tied the aorta. The aneurismal sac burst during the operation. Patient lost about a pint of blood and died in 11 hours.

Stokes' case of iliac aneurism was treated as follows: He made a crescent "C" incision 5½ inches in length in the left side of abdomen, extending from an inch below the tenth rib to the middle of Poupart's ligament. Peritoneum exposed and drawn out of iliac fossa; artery exposed, and a silver wire was passed around aorta immediately above its bifurcation. Patient died in 12 hours. In this case pulsation returned in the left (sound) femoral artery nine hours after operation, showing with what great rapidity the collateral circulation can be established.

Czerny's (of Vienna) patient was a French soldier who received a shattered thigh during the Franco-German War. Secondary hemorrhage occurring, Czerny tied the common femoral and also the superficial femoral below the origin of the profunda femoris. Hemorrhage was arrested for a while, but in 60 days it returned. He then tied the common iliac, but as hemorrhage continued, he thought he had tied the external iliac, and proceeded to apply another ligature, which he placed upon the aorta by mistake. Patient died in 26 hours. In this case 22 hours after operation the injured limb was cold and as if dead, while the opposite limb was warm and had sensation and motion. In the two cases of ligation of the aorta and femoral for wounds was unable to obtain records.

Professor Winslow cites a case of gunshot wound of the abdomen above the umbilicus. The patient died in five days, and at the autopsy a punctured wound of the aorta near the iliac axis was found. Hemorrhage was almost entirely

retroperitoneal. No operation was done in this case.

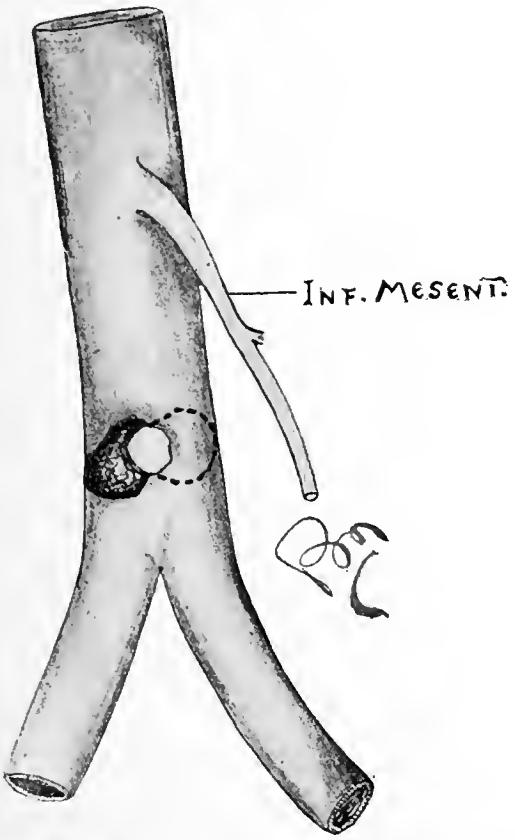
The following case occurred during the service of Dr. St. Clair Spruill:

Case.—L. M., negress, age 20.

History.—Patient brought to hospital in P. M. January 1, 1905, by police patrol, giving history of having been shot in a fight.

Examination.—A small punctured wound was found in the mid-axillary line near the twelfth rib. Profound collapse was apparent. Pupillary reflexes gave feeble response. Palpebral conjunctivae blanched, as was also the buccal mucous membrane; speech feeble and incoherent; pulse weak, thready, rapid and hardly perceptible at the wrist; extremities cold and skin clammy; abdomen ballooned, somewhat tympanitic, and board-like rigidity marked.

Diagnosis of intra-abdominal hemorrhage was made and preparation started for laparotomy.



Operation.—Field of operation was hurriedly shaved, scrubbed and rendered aseptic. Incision was made about four inches long in the left rectus, the center corresponding with the umbilicus. Peritoneum being opened, evidence of marked retroperitoneal hemorrhage was found, the posterior parietal peritoneum encroaching enormously upon the confines of the cavity and pushing forward the mesentery and intestines with much pressure against the anterior abdominal wall.

Incision was made in the posterior parietal peritoneum, large blood clots were expelled and serious arterial hemorrhage was noted. After some difficulty, due to the distorted anatomical relations, a wound in the aorta was found, upon which large clamps were applied. Temporary compression of the aorta between the thumb and index finger was made. Ligation with a small, soft rubber catheter was made about three inches above the brim of the pelvis, catheter being twisted, and twist was clamped with artery forceps and left in situ.

Upon further examination two holes were found in the descending colon through which the bullet passed. This portion of intestines was stitched to the lips of a second incision which was made, extending from the tip of the twelfth rib to the umbilicus. First incision was closed with through-and-through silkworm gut sutures with drainage, and wound dressed.

During the operation the patient was given whiskey, digitalin, strychnine and transfused with warm normal salt solution containing adrenalin chloride 20 gtts. to 1000 c. c.

Anesthetic—Ether. Patient died in about one hour after application of ligature.

Post-mortem.—An antero-posterior perforation of the abdominal aorta about one and one-quarter inches above its bifurcation was found. The bullet, of 38-caliber size, was recovered near the seat of hemorrhage.

AN IRREGULAR CASE OF IMPACTED STONE IN THE LOWER URETER, WITH SOME REMARKS ON THE VALUE OF CYSTOSCOPY, URETRAL CATHETERIZATION, EXPLORATION AND MEATOSCOPY IN THE DIAGNOSIS OF THESE CASES.

By Page Edmunds, M.D.,
Chief of Genito-Urinary Clinic, University of Maryland.

Mr. C. W., aged 26 years, single, occupation coal miner, entered University Hospital January 6, 1905; patient of Dr. Spruill.

Family history unimportant.

Personal History.—Three years ago had an attack of right renal colic lasting three days, at the end of which time he passed a small calculus. He

was free from pain until several months ago, when he had another attack of right renal pain, severe enough to require morphia hypodermically. At irregular intervals of one or two weeks he would have a recurrence, always following, so the patient claims, an excessive indulgence in beer. During these paroxysms he would pass very little urine, but on subsidence of pain he would pass large quantities of pale, limpid urine. Only on one occasion did he pass blood, which was during the first attack, when he passed a stone per urethram. Physical examination negative, neither kidney palpable, nor could a tender spot be elicited at any point either in the groin or iliac region.

Urinalysis of whole urine: Color amber, odor urinous, sp. gr. 1026, sugar negative, albumin positive, red blood and pus cells, epithelium, mucus and urine salts. Referred to me for further examination.

Cystoscopy: At the time of examination patient was perfectly comfortable, having no symptoms whatever. The "Nitze" indirect method was employed, with local anesthesia. Cystoscopy showed normal bladder excepting right uretral orifice, which was very much congested, oedematous, larger than normal, patulous, and situated at the top of quite a large papilla. Both ureters were catheterized; specimen of urine from left kidney normal. On the right side an obstruction to the free passage of the catheter was met about two inches from the vesical end of ureter. Specimen of urine obtained at this point contained red blood and pus cells and many epithelial. The uretral catheter was then passed beyond obstruction to the kidney pelvis, when there was a rush of urine, about 10 c. c., showing that there was a small amount of residual urine in the kidney pelvis. The sensation given the hand by the passage of the catheter through the obstruction was exactly similar to that felt when a sound is passed through an urethral stricture. Specimen from pelvis absolutely normal.

Diagnosis of uretral obstruction two inches from bladder was made, either by stone or stricture, and patient was advised to await developments, thinking as we did that the dilation of the ureter might possibly be of benefit. He went home on January 8, remaining until the 27th of same month, when he returned with the history of an unusually severe attack, following an excess of beer. He was put to bed, given 7½ grains of urotropin every four hours, and prepared in the usual way for operation, which occurred on January 31.

Right iliac extraperitoneal ureterolithotomy was performed by Dr. St. Clair Spruill, assisted by the writer.

The following notes were taken from his chart: Operation 11 A. M., anesthetic ether, drop method. Right ureter catheterized, catheter being passed beyond obstruction to act as guide. An oblique incision of four inches was made in the right iliac region, peritoneum opened and pelvis explored. A lump was found in the right ureter 1½ inches from bladder wall, not movable. The peritoneum was then stripped from pelvic wall down to the base of the bladder, exposing the ureter at this point. A longitudinal incision in the ureter was made one inch long, and a calculus weighing 33 grams and measuring 1.25 c. m. removed.

Urétral incision closed with intestinal silk, peritoneum brought round it, and gauze drain placed in pelvis, but not down to ureter. The appendix was removed at same time.

The peritoneum was then closed with Pagenstecher suture, fascia with same suture, leaving small opening for drain. Muscles were sutured with continuous catgut, skin with silkworm gut. Patient ran normal temperature for three days, when it arose to 101⅗, the highest point during convalescence, which was uneventful.

Urinalysis third day after operation: Color cloudy amber, odor urinous, reaction acid, sp. gr. 1034, albumin positive, sugar negative, sediment contained large number of red blood and pus cells, epithelium and urine salts.

Urinalysis fifteenth day after operation: Color clear amber, odor urinous, reaction acid, sp. gr. 1026, sediment small, containing epithelium, mucus, an occasional pus cell, amorphous debris and urine salts; no red blood cells.

Patient discharged, cured, March 8, 1905.

The comparatively few cases of stone in the lower ureter in the male removed by the iliac extraperitoneal route makes an additional case of interest. Fowler (1) has collected 12 cases of iliac extraperitoneal ureterolithotomies, and 24 cases by all routes. Morris (2) has collected and tabulated 62 cases of stone in the lower ureter, the majority of which were not recognized before operation or autopsy. The case cited above has several features of considerable interest. In the 24 cases mentioned above, the majority had marked vesical symptoms, which were entirely absent in this case, although the trigonum was decidedly congested. Another irregular feature was the partial obstruction of the

ureter, which permitted it to carry on its function under ordinary conditions, giving rise to symptoms only when an unusual amount of fluid was ingested. The small amount of residual urine in the kidney pelvis demonstrated that little damage had been done the kidney by back pressure.

Although there have been several operations employed for removal of stone in the lower ureter in the male, the iliac extraperitoneal route is undoubtedly the operation of choice.

The value of cystoscopy, uretral exploration, catheterization and meatoscopy in these cases is obvious. Certainly by no other means can a diagnosis as to nature and position of obstruction, condition of the kidney above and of opposite side be made, the case cited above being a particularly good illustration. Here the position of the obstruction, probable nature of same, source of pathological constituents of urine, patency of ureter on affected side and health of both kidneys was accurately determined and demonstrated beyond doubt. The surgeon, by the use of the above measures, has data of great value placed in his hands before operation, which a few years ago could only be obtained by an exploratory operation. It is comparatively recent that the iliac extraperitoneal route for removing of stone in the lower ureter has been considered practical, and cystoscopy with its allied measures has contributed largely to its success.

Cystoscopy has rapidly secured for itself an important place in the diagnostic measures of precision. And, like in other methods of precision, there are many possible sources of error, yet in the hands of one skilled in the interpretation of its findings it has become exact. There are many things to be hoped for in refinement of technique, and I feel sure that American cystoscopists, who are rapidly placing upon record their various methods, will take an important place in its future development. The day is at hand when the general surgeon and medical man will habitually seek its aid to clear up obscure genito-urinary conditions.

1.—Fowler (*Annals of Surgery,* December, 1904.)

2.—Morris (*Lancet,* December 16, 1899.)

The Degree of M.D. was conferred on 83 graduates at the commencement of the University of Maryland held on May 13.

A BRIEF REPORT OF NINE CASES OF PNEUMONIA.

By Nathan Winslow, M.D.,
Assistant Demonstrator of Anatomy in the University of Maryland.

In association with my father, Prof. Randolph Winslow, I have seen at the Baltimore House of Refuge this winter nine cases of pneumonia, of which eight recovered and one died. Of course, this number of cases is too small to draw any general conclusions from, yet they may be of sufficient interest to be reported, since the mortality of this disease, as a rule, is much heavier than that enumerated above.

One factor in our favor in the treatment of these cases, however, was the youth and previous good health of all the affected individuals save the deceased, who had always been delicate. There is no need of tiring you with the symptoms of these cases, for you are all sufficiently acquainted with the diagnostic signs of pneumonia; besides, there were no unusual symptoms, all of the cases save three running a typical course, the disease terminating by crisis on the ninth to eleventh day.

In one of these three the temperature dropped to normal on the ninth day, but on the tenth it immediately rose to 101°, and from then until the patient was operated on (about two weeks thereafter) the temperature was of a septic character; consequently we expected empyema, and in paracentesis of the thorax between the sixth and seventh ribs about in the line of the inferior angle of the scapula, our suspicions were confirmed by 10 c. c. of pus being aspirated from the pleural cavity. This boy was removed to the University Hospital, a rib resection performed by Professor Winslow and the empyemic cavity drained, which procedure proved successful. Since then the patient has returned to the Refuge and is convalescent. In this case the pneumonia was located in the upper lobe of left lung; the empyema, however, started in the pleura covering the lower lobe.

The second boy on the above list on the ninth day developed on his right side, over all three lobes, pleurisy with effusion, which was proven by aspirating his chest and removing a half-pint of clear serous fluid. Immediately he commenced to convalesce, and is at the time of this writing practically well.

The third case succumbed on the third day of the disease to edema of the lungs and toxemia.

From this series of cases we therefore have a mortality of 11 1-9 per cent., which is a very low

death rate considering the fact we had a trained nurse in only the first case, all the others being cared for by an untrained nurse; but from the results it can be seen she proved careful and painstaking. The following list shows the lobe and lung affected: Lyons, left lung, upper lobe; Hancock, left lung, upper lobe; Sullivan, left lung, upper lobe; Dean, right lung, lower lobe; Herbert, right lung, upper lobe; Davis, left lung, upper lobe; Waters, right lung, lower lobe; O'Neal, right lung, lower lobe; Mann, left lung, upper lobe.

In five cases the upper lobe, left lung; in three the lower right and one right upper.

The treatment was very simple: Ammo. carb., gr. v, was administered q. 3 hours. Strych. sulph., gr. 1-60, together with spts. frumenti, was given throughout the course of the disease. The bowels were kept open daily with mag. sulph. or an enema of turpentine, glycerine and water. The temperature, pulse and respiration were taken every three hours. If the temperature was 102° or over the nurse was instructed to bathe the limbs for 10 or 15 minutes with equal parts of alcohol and ice water. This procedure not only reduced the temperature, but acted as a sedative; in fact, only in the cases of empyema and pleurisy was the pain severe enough to warrant the administration of morphia, and it may be to the non-use of this drug, as much as any other single factor, we owe a great deal of our success. A pneumonia jacket was employed throughout the course of the disease.

In the last four cases ℥ viii normal salt sol. was administered three or four times a day per rectum. Every case in which it was used recovered. How much its use had to do with the favorable termination of the disease is hard to say, but it is the consensus of opinion that normal salt enemata assist very materially in bringing this malady to a successful end. The first five boys were not treated by this method, and it was in this series that we find our fatal case. Still, I do not believe normal salt solution could possibly have affected the course of the disease in the fatal case, as the patient was overwhelmed by the toxins from the very beginning of his sickness.

Another interesting question is, Why should these cases occur suddenly, almost simultaneously, in an institution with a population of about 200? We are unable to answer this query. No such epidemic of pneumonia has occurred during the previous 20 years of my father's service. One or two cases have occurred occasionally during previous years, but it is doubtful if more than this number of cases have occurred during the whole 20 years. The local conditions are practically the same as previously, with a gradual betterment.

PERSONAL MENTION OF THE ALUMNI OF THE UNIVERSITY.

Dr. G. Wythe Cook of the class of 1879 is one of the most prominent practitioners in the District of Columbia. Dr. Cook resides on Thomas' Circle in Washington. He is an ex-president of the Medical Society of the District of Columbia and of the Alumni Association of the University of Maryland in Washington. He is also professor of clinical medicine in the Medical Department of Columbian University. Dr. Cook is widely known as a teacher and practitioner, and is respected and beloved by all who know him for his upright character and kindness of heart.

Dr. O. H. W. Ragan of the class of 1874 is one of the best-known physicians in Western Maryland. Dr. Ragan resides in Hagerstown and is one of the most enterprising citizens of that progressive city. He has a large practice and is surgeon to the railroads centering in Hagerstown, as well as examiner to a number of the most prominent life-insurance companies doing business there. He is married, but has no children. He is a warm friend of the University, and by his useful life as a physician has reflected great credit upon his Alma Mater.

Dr. R. C. Buck of the class of 1874 is located in Orlean, Fauquier county, Virginia. Dr. Buck has practiced his profession with marked success in his community and is most highly respected for his skill and attainments. He has worked in a laborious field requiring strenuous labor to meet the many calls upon his time and service. He has found time to keep pace with the progress of his profession and is one of the best-informed physicians of our acquaintance. The doctor is also a student of literature and of science. His modesty and retiring nature have led him away from the showy paths of his profession, and only those who know him intimately are aware of his attainments. He is, like many of the best men in our profession, a man of action rather than a man of words. Knowing well the calls of duty, he has given his time and skill to the people who employ him, and, like good old Dr. McClure, he is most loved and respected by those who know of his charity and unselfishness.

Dr. R. H. Lewis of the class of 1871 is one of the best-known specialists in eye and ear diseases in North Carolina. Dr. Lewis is located in Raleigh. He has taken the most active interest in the work of the State Board of Health and has done much to develop the work and influence of this board in his State. He is also an ex-president of the Medical Society of the State of North Carolina. He is most probably one of the best-known and most influential members of the profession in his State.

ABSTRACTS AND EXTRACTS

Intubation Experiences.—In the *Maryland Medical Journal,* April, 1905, Dr. Wm. T. Watson of Baltimore (1891) gives his experience with this operation since 1895, 109 cases. It has constituted his most satisfactory professional work.

One hundred received antitoxin, of whom 78 recovered, 22 died; 81 were in the practice of other physicians, and of these 23.5 per cent. died; 19 were in his own practice, and of these 15.8 per cent. died. One-fourth of the cases were under two years, and 60 per cent. of the deaths occurred in this fourth.

Nine received no antitoxin. Of these three were diphtheritic cases, of whom two died.

The ages of patients have ranged from six months to 12 years.

Difficulties are encountered in the operation from improper position, spasm of larynx, too large a tube, vomiting in succeeding intubations, struggling of the patient, falling of epiglottis over tube during anesthesia, pushing down loose membranes before the tube, abnormality of larynx, rapid return of stenosis, the necessity of retaining the tube for several or many weeks. Experience seems to have shown that five days is the proper time for retaining the tube in antitoxin cases. The author usually waits a day or two longer if the child be taking food well, in the hope that the tube may be coughed up or that the necessity for intubation will be diminished. The present hard rubber tubes allow of this delay. In three cases such tubes have been left in three weeks. The author has had six cases in which the tube had to be kept in from 17 to 84 days and requiring from three to seven, and in one case 34, introductions. All these made perfect recoveries. In feeding, children at the breast usually nurse well; in those who take the bottle, the Casselburg method should be employed, *i. e.* with the head down, which permits swallowing and the draining of mucus from the trachea into the pharynx. In two cases nasal feeding proved easy and satisfactory. There was but one death from an obstructed tube—an infant of 11 months. There is no avoiding this except by having physician and assistants continually in the room. In older children the loosening of membrane usually causes expulsion of tube with membrane. The tube should, therefore, not fit tightly. The tube may gradually fill up, and must then be removed and cleansed. No serious accidents are recorded from swallowing the tube. There was no case of paralysis in the series.

Broncho-pneumonia, according to Holt, exists in three-fourths of fatal cases. In cases where the larynx is involved the early use of serum will obviate the necessity for intubation in about 50 per cent. of cases. The author believes in *early intubations,* and says when in doubt intubate, and for two reasons: (1) The stenosis may become suddenly worse in the physician's absence; (2) the tendency of broncho-pneumonia may thereby be lessened.

The few surviving members of the class of 1873 will recall a fellow-student who was well known for his blunt, unaffected and honest mannerisms. An overgrown boy at the time he graduated, he has developed during the years which have intervened into one of the leading men in his profession in his State. The crude material in the boy has been so refined by professional life that few would recognize the man as now developed. The classmate to whom we refer is Dr. D. W. Bullock of Wilmington, N. C. Dr. Bullock has become one of the leading surgeons of his section of his State. He has a large and successful practice and is one of the most respected citizens on his city.

Dr. John Williamson Palmer (1846), the distinguished poet and author of "Stonewall Jackson's Way" and other poems, celebrated the eightieth anniversary of his birth amid a multitude of congratulations and flowers at 1104 McCulloh street, Baltimore, on April 4.

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EDITORIAL

THE CLASS OF 1905.—It is a pardonable pride which influences each graduating class to assume a superiority over preceding classes. Encouragement is given to this claim by the usual announcement made to the graduating class by the orator who introduces the class to the Alumni Association at its annual banquet. The statement is made, we believe, in good faith that "the present class is the best class ever graduated from the University." If this statement is not correct we must assume that no progress is being made from year to year in methods of instruction and in requirements of examination. This fact we cannot admit. It is evident to those who watch closely the methods of instruction at the University that the curriculum is widened each year and the difficulties in the way of graduation are increased. The students of the present class have been carried through a more severe ordeal than those of previous classes, and, therefore, should be better equipped for professional work than their predecessors. If, however, the present class thinks that it has had a most trying ordeal to go through in winning the M.D. degree, what will succeeding classes have to say in this respect? The conditions of study and of requirement must increase from year to year, and those who take up the profession of medicine must expect more exacting burdens than are now imposed on the student. The State examining boards are gradually raising their standards of requirement, and the medical schools must meet these conditions which are presented to their graduates. No first-class school can remain indifferent to these facts. The University is in full sympathy with this demand for better methods of instruction, and will leave no stone unturned to meet the requirements of its students. The young men who come to the University must understand that much will be expected of them and that much will be given them.

Referring to the class of 1905, it is pleasant to announce to the Alumni of the University that its personnel is good and that the class, as a whole, will fully sustain the reputation of preceding classes. It contains many men who should reflect great credit upon the University in professional work. The BULLETIN will watch the subsequent development of the different members of the class and hopes to keep in touch with all of them as far as it may be possible to do so. The BULLETIN asks that each member of the class will send personal notices to it, such as announcements of marriages, of appointments to public positions, of changes of residence and of such matters as may be of special interest to old classmates. The BULLETIN also invites contributions to its columns of such papers or reports of cases as may be of professional interest to its readers.

THE GARCIA CENTENARY.—The celebration of the one hundred and first anniversary of the birthday of the discoverer of the laryngoscope in London on March 17 was a most striking event. The interest in the event commemorated was greatly enhanced by the circumstances connected with it—his great age, his remarkable vigor and the fact that he was a Spaniard by birth and not a physician, but a distinguished musician and teacher of vocal culture. Manuel Garcia was born in Madrid in 1805, his father being a famous operatic tenor and composer of many operas. At the age of 10 he joined his parents at Naples. His mind turned rather to the scientific side of music, and he early gave up singing to devote himself to teaching. In 1835 he became professor in the Paris Conservatoire, and in 1848 he was driven thence by the revolution to London, where he has ever since resided and taught as professor in the Royal Academy of Music until 10 years ago, when he retired. Among his pupils have been singers of world-wide fame, as Jenny Lind, Christine Nilsson, Charles Santley, Mathilde Marchesi and many others.

Garcia himself states that the idea of employing mirrors for the study of the larynx came to him one day in September, 1854, when he was strolling in the Palais Royal "preoccupied with the ever-recurring wish so often repressed as unrealizable." He immediately went to the instrument maker's, and procuring a dentist's mirror and a hand mirror, returned home and began his ex-

periments. He placed against the uvula the little mirror (first heated in warm water and carefully dried), then flashing upon its surface with the hand mirror a ray of sunlight, he saw at once, to his great joy, the glottis wide open before him and a portion of the trachea. On March 22, 1855, his epoch-making paper, "Observations on the Human Voice," was communicated to the Royal Society, and in the same year it was published in the proceedings of that society. Professors Türck, of Vienna, and Czermak, of Buda-Pesth, applied the great discovery subsequently to the diagnosis and treatment of diseases of the larynx. Garcia himself does not appear to have made any use of his discovery in teaching, and, of course, not being a medical man, he could not apply it to medicine.

The credit due to him, nevertheless, for the discovery is unquestionable, and, therefore, he has worthily received the homage of sovereigns, nations, societies, universities and individuals. As Sir Felix Semon said, "Millions of human beings have been benefited by his invention," and he justly deserves the title of "Father of Laryngology" which has been given him.

Ambidexterity.—The faculty of using either hand at will by the surgeon has always been regarded as highly to be desired and to be sought after by the surgeon. Among the ancients, as we learn from Celsus, it was esteemed as among the necessary qualifications of the art. The aspersion cast upon the left hand in the use of the word sinister has no foundation in heredity, not being observed in the young infant. Not only is the limitation of our most important and skillful functions not of necessity limited to one hand, but a little reflection will show that it is solely the result of custom. Much may undoubtedly be done to confer greater usefulness on the less-used member, especially if the attempt be begun early. Exercise will bring about surprising results in this direction, and those who contemplate a surgical career should by all means practice such training. As Brown-Sequard has pointed out, there are many motor cells in both our brains and cords which are absolutely useless to us for want of this training, and there is no doubt we leave these important organs in a rudimentary state by such unnatural neglect. It is an interesting fact that there is a society in London devoted to ambidextral cultivation.

The Hall of Fame.—Of the 29 names selected for the Hall of Fame in the University of New York, not one is that of a physician. Whether our profession will be represented in the 26 to be added during the present year it is impossible to say, but in view of the probability of such an event, it is interesting to consider who would be most likely to be selected for the high honor. Benjamin Rush stands, of course, pre-eminent, not for any one lasting or signal discovery in the realm of medicine, but rather for the totality of his life and achievements. He lived in the infancy of the republic and in its medical metropolis, and he is the greatest figure of his times, a forceful teacher and writer as well as practitioner. The glamor of a signer of the Declaration hovers about him also. Whilst it is not difficult to agree upon Rush, one cannot so readily decide upon the next name. It seems to us that in the selection we should have regard to a man's achievements in medicine itself, rather than in the by-paths of literature, politics, etc. Therefore, we would hesitate to bring forward, for instance, David Ramsay, best known as a historian, and Oliver Wendell Holmes, who, however famous as poet and writer, has but one medical article to his credit. Valentine Mott, the great surgeon, John Collins Warren, the first to use anesthesia, Ephraim McDowell, the ovariotomist, J. Marion Sims, the gynecological surgeon, Walter Reed, the discoverer of the mode of origin of yellow fever, seem to us to be more entitled to our suffrages. There are many who enjoyed local celebrity and who doubtless would carry off the vote of their respective sections. Our own great surgeon, Nathan R. Smith, for example, would doubtless be considered by his pupils eminently worthy of a niche in any temple of fame. The two greatest achievements of American medicine were undoubtedly the discoveries of anesthesia and the cause and prevention of yellow fever, and it would seem, therefore, imperative that these discoveries should bear some part in the settlement of this question. The names of the dentist Morton and the army surgeon Reed thus loom up as those who should receive the first consideration. In presenting their names we are not called upon to go into explanation and argument —their benefactions to mankind are known to all the world.

The annual meeting of the Alumni Association of the Medical Department of the University of Maryland was held at the Eutaw House on May 11.

BOOK REVIEWS

THE SURGICAL TREATMENT OF BRIGHT'S DISEASE. By George M. Edebohls, A.M., M.D., LL.D. New York: F. F. Lisieki. 1904. 8vo.

The idea of surgical interference in chronic nephritis was suggested to the author accidentally while anchoring movable kidneys — nephropexy. Venturing to extend this operation to cases of chronic Bright's disease, simply with the view of relieving the "intolerable symptoms" present, he was surprised to find that a large proportion of these cases were cured. He also made the important observation at this time that chronic nephritis was frequently unilateral. At first he attributed the favorable results entirely to the fixation; later he satisfied himself that it was consequent upon the denudation of the organ, and consequently he adopted this operation in *all* cases of chronic inflammation, whether movable or not. This was in May, 1901. The rationale of the cure was explained as due to relief to renal circulation by the free opportunity thus afforded for the formation of new vascular connections on a large scale between the blood vessels of the kidney and its capsule. It resembled that applied to the modern surgical treatment of cirrhosis of the liver.

The operation is described in detail at p. 50. In brief: The patient being placed prone with the author's kidney cushion underlying the abdomen, an incision is made from the twelfth rib to the crest of the ilium along the outer margin of the erector spinae. Division of the transversalis fascia exposes the perirenal fat, which is divided until the capsule proper is reached. The kidney should be brought into the wound or beyond if possible. The fatty capsule is next separated from the capsule proper, with scissors and knife if necessary. The capsule proper is then divided on a director along the length of the convex external border, each half being stripped off and finally cut away close to the pelvis. The kidney is finally dropped into its bed and the external incision closed. Both kidneys, if necessary, should be operated on at one sitting, so as to avoid the grave danger from double anesthesia. The operation requires one-half to one hour, and the patient should be kept in bed and on his back for two or three weeks.

The author's experience up to the close of 1903 embraces 72 cases, of whom 13 received no benefit, while 59 experienced amelioration varying from slight and temporary improvement to (in 17 cases) complete cure. Seven deaths followed close upon the operation.

With true scientific candor, the author admits that a much longer period is necessary before final judgment can be passed upon the real and full value of renal decapsulation for chronic Bright's disease, but points out that the immense majority of his patients came for operation only after all other measures and treatment had failed to arrest the unrelenting deathward progress of their chronic nephritis. He, therefore, feels justified in adopting such treatment and in holding that surgery is at present the main, if not the only, hope of sufferers from a hitherto incurable malady.

E. F. C.

A TEXTBOOK OF LEGAL MEDICINE. By Frank Winthrop Draper, A.M., M.D. (Harv.) Messrs. W. B. Saunders & Co., Publishers.

Legal medicine within the past 10 years has assumed a degree of importance never before known, and from being an obscure subject, except to a few experts, it is now taught to medical students, and no school of medicine is fully equipped for the work before it unless it gives its students at least an outline sketch of medicine in its relation to law. As the books of a people tell us of what and how they are thinking, so the number and character of the works on legal medicine tell us of what the medical world is thinking about today. The gathering together of vast numbers of people in our large cities and metropolitan centers not only serves to increase the opportunities for crime, but at the same time provides a way for its concealment, and thus the difficulties of its detection are increased. Our present mode of living endangers life and makes it difficult for many to save any considerable amount from their earnings, hence life insurance has grown to enormous proportions, and as it requires the services of medical men and often brings them into the closest relationship with the law, the necessity of a knowledge of legal medicine is brought forcibly to the attention of the medical profession. As a result of all this we have in our possession many valuable books dealing with medical jurisprudence from the recently-issued 329-page edition of Dr. Chapman's Manual to works of two or more volumes. Messrs. Saunders & Co. have just issued from their press a work on legal medicine, and a few words in regard to it may not be out of place.

The work of Dr. Draper is in a single volume of 573 pages, the printing is well done on thick

paper, the letters are clear and of good size. The paper is glazed and reflects too much light. Several books that we have had lately have been very objectionable on this account; one in particular was so highly glazed as almost to forbid its being read at night. Publishers would confer a great favor on readers if they would pay more attention to this matter and let us have a "dead" surface on our reading pages.

The book opens with an introductory chapter in which the subject is defined, and occasion is taken to defend the teaching of it as a separate branch. In this chapter the passing of the "coroners' juries and coroners' inquests" in "Massachusetts and some other States" and the new method of procedure are noted. Whether the system adopted in Massachusetts, where a "medical examiner" under bond takes the place of the coroner, could be as successfully managed in all places may be open to question. The second chapter deals with "Medical Evidence and the Medical Witness." The matter is well presented in a condensed form. Then follows the important subject of "Identity in Its General Relations" and of "Sex and Doubtful Sex." "Personal Identity" receives the share of attention its great importance deserves, and here we are glad to note the attention that has been bestowed upon the "impressions left by the human foot" and that of "the papillary ridges in the skin at the bulbs of the fingers." The illustrations (from Ewing) showing these ridges in five-finger prints are good, and the story of how a thief was detected by this means serves to emphasize the growing importance of securing finger impressions as a means of identification. One chapter is given to "Impotence and Sterility," especially as these relate to adultery, divorce and rape. Too much space is not given to rape in the three chapters which treat of it. The subject presents many difficulties, and the matter is elucidated by plates showing "Normal Hymen" and "Defloration." The next two chapters treat of "Criminal Abortion." In referring to the testimony which has resulted in having abortion spoken of as an "American crime" the author says: "We do not deserve all the bad things said of us; at least, we are not worse than our neighbors beyond the ocean," and we are pleased to note the defense. "The signs of death" and their relative importance are next taken up. Although the evidence seems clear that one is not likely to be buried alive, still one such case, as that of Senator Plumb, as the author relates, should serve to make us careful and thorough in our examination of every case of supposed death. Instead of adopting the classification of the causes of death, as is done by many "French, English and American medico-legal writers"—that is, the failure of one or more of the three great vital functions, respiration, circulation and innervation—he places all deaths in one of two classes—those which result from natural causes and those which result from violence. We much prefer "the more precise and specific basis." Rigor mortis, cadaveric spasm and putrefaction come in for their full share of recognition. Under "Cadaveric Spasm" the quotation from Dr. Weir Mitchell's book, "Characteristics," is especially apt as showing how such a condition may serve to clear up difficult situations. Thus, if one is found dead with a weapon grasped in the hand, was the death homicidal or suicidal? In the next chapter, "Sudden Death Due to Natural Causes," the tables compiled from the author's cases are interesting. Alcoholism leads the list with 21 per cent., pneumonia second with 19 per cent., and heart disease a close third with 18 per cent. Deaths from heart disease are treated at some length, as they deserve to be. Then follows a full discussion of the modes of death by asphyxia — drowning, hanging, strangulation and suffocation—one chapter to each. In noting the internal appearances in death by drowning we were pleased to find emphasis laid upon the presence of foam in the air passages, the author concluding by saying: "This absolute constancy of the presence of foam, whatever the special conditions in which the submersion occurred, is, according to these authors, the single, sure, uniform sign proving death by drowning." Chapters XIX to XXII, inclusive, are taken up with the consideration of "Wounds." The emphasis given to the legal in contradistinction to the surgical definition of a wound and the great importance of a study of wounds from a legal point of view is timely. The author says: "Exclude from the books and from common medico-legal experience everything relating to wounds, and it will be found that the remnant is of small importance." Would all agree to that statement? The discussion of "Infanticide" follows that of wounds. The old hydrostatic test is still regarded, and justly, by the author as the most reliable one for determining whether a child has breathed or not. The "Medico-Legal Relations of Human Blood" has a chapter devoted to its discussion, with plate illustrations. This subject has lately attained a great degree of importance, and the space given

to Formad's table and test for blood is well used. Unusual forms of death by electricity, heat, cold and starvation follow. One short chapter only is given "Murder by Poisoning," and it would seem as though this difficult subject has not received the attention it deserves. If some of the matter contained in the earlier portion of the work had been curtailed and more space allotted to poisoning, the readers would have profited by the change. The rôle played by "Noxious Gases" in medico-legal enquiries is fittingly discussed in chapter XXXI. The work closes with a chapter devoted to a consideration of "The Physician's Legal Relations to His Patients" and one to "A Medico-Legal Autopsy." We should like to have seen a chapter on "Life Insurance," without which a work of the scope of this one hardly seems complete.

The work as a whole is a valuable addition to our medico-legal library, and we are grateful to the author in that he has given us the result of his experience of 28 years as medical examiner of such a large city as Boston, with its many and varied opportunities. During this period over 8000 deaths under a suspicion of violence came under his observation.

As a book for the student and practitioner we are pleased to note the absence of long statistical tables and theoretical discussions. J. T. S.

NOTES AND ITEMS

Dr. Howard Ames of the class of 1874 soon after graduation entered the United States navy as an assistant surgeon. Dr. Ames has now reached the full grade of surgeon and is at the present time stationed at Annapolis. Dr. Ames delivered the address before the Alumni Association of the University at its recent annual meeting. It was pleasant to his old classmates and friends to meet with him after so many years. He is the same genial gentleman as of old.

Three works are about to be issued by medical alumni of this institution shortly, two by Drs. Samuel Theobald (1867) and Theodore Cook, Jr. (1891), on the "Eye," and a third by Dr. W. A. B. Sellman (1872) on "Gynecology."

Dr. Daniel of St. Thomas Jenifer (1904) of Loch Raven, Baltimore county, Maryland, has been appointed resident physician to the Atlantic City Hospital.

The following subscriptions have been made recently to the Endowment Fund: William Knabe & Co., $25; John A. Horner, $5; Dr. T. D. Burgess of Matewan, W. Va., $10.

We are informed that the degree of LL.D., *causa honoris*, will be conferred upon Prof. John C. Hemmeter, M.D., Ph.D., at the approaching commencement of St. John's College, Annapolis, and he will deliver the address upon the occasion.

The Washington Alumni Association held its annual meeting and banquet May 2. Dr. I. S. Stone read a sketch of the venerable professor-emeritus, Dr. George W. Miltenberger. This is the only alumni association known to us outside of Baltimore, and it reflects much credit upon the *esprit de corps* of our Washington brethren.

Dr. James H. Miles (1845) of St. Inigoes, St. Mary's county, Maryland, though in his eighty-third year, is still hale and hearty, often dances a jig and attends all the meetings of the county school board, of which he is a member. He recently rode 25 miles in less than three hours.

Dr. Compton Riely (1897), one of the staff of the Hospital for Crippled and Deformed Children of Baltimore, read a paper before the American Association for the Advancement of Physical Education, which met in Columbia University, New York city, on April 17. His subject was "The Etiology, Prophylaxis and Treatment of Lateral Curvature of the Spine."

The following-named physicians have been recent visitors to the University Hospital:

Dr. N. S. Dudley (1901), Church Hill, Md.
Dr. M. A. B. Smith, Halifax, Nova Scotia.
Dr. D. Thompson (1901), Warren, N. C.
Dr. H. C. Chappelear (1897), Hughesville, Md.
Dr. T. M. Dulin, Clover, S. C.
Dr. Maclane Cawood (1902), West River, Md.
Dr. J. Hill, Lexington, N. C.
Dr. A. B. Eagle (1904), Martinsburg, W. Va.
Dr. R. S. Lansdale (1902), Damascus, Md.
Dr. L. B. Henkel (1903), Annapolis, Md.
Dr. R. S. Lyell (1902), Warsaw, Va.
Dr. G. W. Latimer (1901), Hyattsville, Md.
Dr. H. V. Dutrow (1904), Frederick, Md.

Over $100 were realized by the three recent entertainments of the Young Men's Christian Association. With this needed furniture has been purchased and $25 laid aside for the piano fund. The association was greatly aided in this work in the sale of tickets by the ladies' auxiliary of the hospital.

The following alumni of this school were elected officers of the Medical and Chirurgical Faculty of Maryland for the ensuing year on April 26: Samuel T. Earle, Jr. (1870), president; Charles O'Donovan (1881), first vice-president; Thomas Morris Chaney (1866), second vice-president; Joseph B. Seth, Jr. (1899), third vice-president.

Dr. James Carroll (1891), of the Army Medical School, Washington, D. C., has just returned from Galveston, where he delivered a lecture, on "Yellow Fever," under the auspices of the University of Texas.

There were 76 graduates at the Commencement of the Department of Dentistry on May 8. The University Gold Medal was taken by Dr. James Stephenson Hopkins.

Dr. Charles A. Wells (1862), has been elected Mayor of Hyattsville, Md., his fourth successive term.

The following officers were elected at the annual meeting of the Alumni Association of the District of Columbia, held May 2: President Dr. Thos. A. R. Keech; vice-presidents, Drs. C. H. Howland and Francis B. Bishop; secretary-treasurer, Dr. W. P. Malone; corresponding secretary, Dr. W. M. Simpkins; executive committee, Drs. I. R. Stone, J. Ford Thompson, R. A. Bates, W. N. Souter, and E. Oliver Belt.

Dr. J. B. R. Purnell (1850), was married about May 4 to Miss Margaret R. Spence, a teacher in the John B. Stetson University, De Land, Fla., at De Land, Fla. Dr. Purnell is a resident of Snow Hill, Md.

It has been proposed that the Bar Association erect a building which shall serve for its meetings, for the housing of the Bar Library and for the uses of the Faculty of Law of the University of Maryland. Club features are to be added. Major Richard M. Venable is at the head of the project.

The Library and Historical Society has adjourned for the summer, having held its last meeting on April 13. A letter was read from Dr. Wm. T. Howard, accepting the honorary presidency.

Dr. J. Homer Wright (1892), has taken the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, amounting to $1,200, for an essay on "The Biology of the Micro-organism of Actinomycosis." Dr. Wright is connected with the pathological department of Harvard University.

The following appointments were made to the Staff of the University Hospital for the year beginning June, 1st, 1905:

Department of Surgery.

F. G. Wright, M. D., of Virginia.
Chas. Bagley, Jr., M. D., of Maryland.
J. G. Matthews, M. D., of Maryland.
J. W. Pierson, M. D., of Maryland.

Department of Gynecology.

R. L. Mitchell, M. D., of Maryland.
H. E. Jenkins, M. D., of Virginia.

Department of Medicine.

R. C. Metzell, M. D., of Maryland.
R. P. Bay, M. D., of Maryland.
J. H. Smith, Jr., M. D., of Maryland.

Department of Obstetrics.

H. D. Purdum, M. D., of Maryland.
W. B. Warthern, M. D., of Georgia.
K. W. Brabham, M. D., of South Carolina.

Pathologist to Hospital.

A. L. Quillan, M. D., of Delaware.

Bayview.

W. H. Smithson; M. D., of Maryland.
W. J. Reddick, M. D., of North Carolina.
S. L. Bare, M. D., of Maryland.
G. W. Mahle, M. D., of Maryland.

St. Joseph's.

E. H. Adkins, M. D., of North Carolina.
S. R. Clark, M. D., of Maryland.
H. C. Irwin, M. D., of North Carolina.

Hospital for Women of Maryland.

Julian W. Ashby, M. D., of Virginia.

A frog from which the brain was removed, and which was long an object of great interest, has just died at Cornell University. It was kept for five years in a large open jar and never showed any signs of initiative, its only movements being very slight and attributed to muscular weariness, like that of sleep. The eyes, optic nerves and optic lobes of the brain were uninjured, and the animal could evidently see, but without understanding. The most attractive food put before it was absolutely unnoticed, and it was fed every day by opening the mouth, and, with forceps, pushing a bit of fresh meat or fish far back in the throat so as to arouse the reflex mechanism of swallowing. If touched, the body would move or leap; if placed in water, it would swim until some support was reached; if turned on its back, it would promptly right itself, but it never moved of its own accord.

The degree of M. D. was conferred on the following graduates at the commencement held May 13:

Adkins, H. E.
Ashby, J. W.
Bare, S. L.
Bay, R. P.
Benner, C. M.
Billingslea, J. S.
Bohannan, A. P.
Brabham, V. W.
Brooks, B. U.
Burden F.
Burns, I.
Carnal, R. C.
Carroll, J. Jr.
Casey, E. L.
Chappelier, F. D.
Clarke, S. R.
Copeland, E. V.
Croom, A. B.
Croushore, C. C.
De Blois, S.
De Vanny, D. A.
Disosway, A. W.
Dueno, M.
Dwyer, J. E.
Elderdice, J. M.
Ellis, O. J.
Felton, H. M.
Fenner, E. F.
Fisher, W. H.
Gibson, J. S.
Gibson, M. R.
Goldback, J. L.
Graham, A. W.
Hala, W. W.
Hammond, S. W.
Harris, R. V.
Harrison, G. B.
Hodgin, H. H.
Houck, H. C.
Irwin, H. C.
Jamison, B. I.
Janney, F. W.
Jenkins, H. E.
Kafer, O. O.
Kenawy, N.
Kerr, E.
Kneisley, H. L.
Knell, W. A.
Koury, K. M.
Le Fevre, E. B.
Levin, J.
Mahle, G. W.
Matheson, J. P.
Matthews, J. G.
McCarty, G. S.
McCarty, H. D.
McGuire, J. P.
McGuire, W. C.
Metzell, R. C.
Miner, H. E.
Mitchell, R. L.
Mitchell, W. M.
Nice, J. A.
Owens, O. S.
Parker, J. W.
Parvis, W. A.
Pierson, J. W.
Remsberg, D. E.
Revell, S. T. R.
Riddick, W. J.
Riha, W. W.
Riley, J. L.
Rooks, J. E.
Rytina, A. G.
Salley, E. M.
Sanders, A. L.
Sherard, S. B.
Smith, J. H., Jr.
Smithson, W. H.
Stone, J. A.
Tefft, B. F., Jr.
Tyson, W. E. E.
Waas, F. J.
Warthern, W. B.

At the Commencement of the Training School for Nurses connected with the University Hospital held May 10th, the following nurses were graduated:

Nellie Rives Ferrell, Virginia.
Nellie Harrison Hilliard, North Carolina.
Ruth Rozalia Kuhn, Maryland.
Dora Iola Brosenne, Maryland.
Carlotta Lee Schaefer, Maryland.
Leila Griffith Owings, Maryland.
Eleanor Virginia Gildea, Virginia.
Lila Holmes Trenholm, Maryland.
Letty Terry Jones, Virginia.
Elizabeth Richards Bayly, Virginia.
Millicent Geare, Maryland.
Margaret Brand Cowling, Massachusetts.

Annual meeting of the Alumni Association of the Medical Department of the University of Maryland was held at the Eutaw House on the evening of May 11. The attendance was the largest in the history of the Association, 106 members being present in addition to the graduating class of 1905.

The annual address was delivered by Surgeon Howard E. Ames, U. S. Navy, of the class of 1874. Dr. Ames took as his subject "Thirty Years' Experience in the Navy." He spoke first of the work done by the Medical Staff of the Navy and of the wide range of duties required of them. He next gave a most interesting account of the rescue of the Greely Arctic Expedition. He was surgeon of the relief expedition which found Greely and his fellow-explorers. His account of the trials and sufferings of the survivors of the expedition and of the work of rescue was most interesting. Dr. Ames expressed the opinion that the failure of the expedition was due largely to the fact that its officers and men were army men and were not sufficiently skilled in seamanship to successfully cope with the difficulties which they met.

The following officers were elected for the ensuing year:

President—Surgeon Howard E. Ames, United States Navy.

Vice-Presidents—Drs. Charles O'Donovan, William H. Pearce and C. R. Winterson.

Recording Secretary—Dr. Charles E. Sadtler.

Assistant Recording Secretary—Dr. J. A. Zepp.

Corresponding Secretary—Dr. George H. Hocking.

Treasurer—Dr. G. Lane Taneyhill.

Executive Committee—Drs. Wilmer Brinton, John I. Pennington, Joseph T. Smith, S. B. Bond and T. O. Heatwole.

The following committee to have charge of the arrangements for the centennial celebration in 1907 was appointed: Drs. G. Lane Taneyhill, E. F. Cordell, B. M. Hopkinson, Wilmer Brinton, John T. King, C. E. Sadtler, James H. Jarrett, J. I. Pennington, W. F. Skillman and A. D. McConachie.

Dr. Wm. T. Councilman, Professor of Pathology at Harvard, writes to the *Baltimore Evening News*, complaining of the duty imposed on the owner of a microscope sent to Germany for repairs. The charge for a lens that had been repaired was $14.50 and it is still held at the custom house at Boston. The Secretary of the Treasury says no relief can be afforded.

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NOTES ON THE TREATMENT OF ACUTE PNEUMOCOCCUS PNEUMONIA WITH NORMAL SALT-SOLUTION ENEMAS.

BY JAS. M. CRAIGHILL, M.D.,

Assistant Professor Clinical Medicine, University of Maryland.

It is a well-known fact that we have, it may be said, no treatment of pneumonia which is better than our forefathers had 50 years ago.

The very fact that so many different drugs have been brought forward as a specific for pneumonia proves that up to the present time nothing has been found that may be claimed to reduce the mortality. It is also a well-known fact that the mortality in hospitals is much greater than in private practice, amounting on the average to about 25 per cent., and even at times rising as high as 40 per cent. Of course, it is also recognized that this high mortality is due to the character of cases which have to be treated in the hospitals, owing to their lowered vitality from alcohol, other vicious causes, and also because many of these people do not arrive in the hospital until almost moribund.

During the winter of 1904 the mortality at the University Hospital from this disease had at one time risen to about 40 per cent., and from reliable information it was understood that the same high mortality existed in some of the other large hospitals of this city.

My friend, Dr. Chas. W. McElfresh, went on duty as visiting physician February 1, 1904, and commenced the use of salt enemas in all cases where it could be used and was thought indicated.

The mortality immediately was much reduced, and as he had some very unpromising cases to deal with, it appeared to me a rational proposition to continue this treatment when I succeeded him in the service at the hospital. In my service of April and May, 1904, and February and March, 1905, I had 21 cases of pneumococcus pneumonia to treat, with three deaths.

The first case of death was in a man 24 years of age, suffering not only with pneumonia of left apex, but complicated by a meningitis and an endocarditis. Salt enemas were used in his treatment.

The second death was of a man aged 33, in whom the whole right lobe was involved. Salt enemas were used in this case.

The third death occurred in an old negro, aged 55, who was suffering with a non-compensating heart, with leaks at all of his valves. His condition was such that death was expected a number of times before the pneumonia came on, and as he died suddenly, his heart was probably the cause of his demise, and not the pneumonia. No salt was used in his treatment.

Of these 21 cases, 16 had the salt enemas given them—one-half pint every six hours during the acute stage.

The enemas are better borne if given about the same temperature as the body, thrown in slowly, and rather high up in the bowel. Where the patient cannot retain the salt solution, he should be encouraged to drink as much pure water as can be comfortably taken, thus in another way diluting the toxins in the blood as much as possible, and causing the kidneys to act more freely and carry off the poisons in the system.

Possibly where the right heart has become dilated and engorged, and bleeding indicated to relieve that condition, it might be wrong to put more fluid in the shape of saline solution into the circulation for the already overtaxed heart to have to propel through the system.

Carb. ammonia was given to most of these patients, and where more stimulation was thought necessary recourse was had to strychnia and whiskey.

When the temperature ran high cold sponging was done, and in many cases the ice cap was applied to the head.

The highest temperature reached by any of

these cases that lived was 105⅘ per mouth, the lowest 100⅕, with an average of 104⅘ for the maximum. The ages varied from 58 to 13, with an average of 31 years.

The writer is aware that salt solution in this disease has been in use for some years past, and is not an original treatment at the University of Maryland Hospital. It is also very evident that with a disease so varying in its mortality in different seasons and localities so few cases prove little.

My observation of this treatment would lead me to believe it to be in the right direction not only in saving lives, but also in shortening the duration of the disease.

UNILATERAL HEMATURIA FROM NEPHRITIS.

By St. Clair Spruill, M.D.,

Clinical Professor of Surgery, University of Maryland.

This subject, which only a short time ago was regarded as a purely medical one, is so broad that I shall not attempt in this paper to enter into the etiology as minutely as should be done. I want to speak more in detail as to the mode of diagnosis and to show how impossible it is in some few cases to arrive at a definite diagnosis except by microscopic examination of sections from the kidney.

The commoner causes of hematuria are as follows: urethritis; from the bladder—stone, tubercular ulceration and papilloma; from the kidney—tuberculosis, malignant growths, stone, nephritis, functional hematuria and malarial poisons.

Of these causes of hematuria, tuberculosis, stone and nephritis are the most commonly seen.

As to the method of diagnosis, it is easy to demonstrate the presence of blood in the urine first; then a cystoscopic examination of the bladder should be made, and if this fails to establish a diagnosis, the ureters should be catheterized.

Having collected the urine from each kidney, and by examination shown from which one the bleeding is taking place, the probabilities in order of frequency are tuberculosis, stone and nephritis.

If the hemorrhage is shown to come from both kidneys, functional hematuria, nephritis, malaria or some poisoning should be suspected.

Functional renal hematuria is important, and in a great many instances has led to the making of a wrong diagnosis, and in a few cases nephrectomy has been done. Klemperer has reported a number of cases in which hematuria was present, but which showed no kidney lesion whatever after death. He called these angio-neurotic renal hematuria. Senator reports quite a number of these, and gives a synopsis of the symptoms present—acute paroxysms of pain, constitutional disturbances, interference with micturition and other symptoms—which led to a diagnosis of either renal calculus, tuberculosis or new growths. His collected list includes five cases, all of which at operation revealed a normal kidney.

Schade likens this condition to menstruation in the female. Sabatiers terms it hematuric nephralgia. These are simply terms without explanation, and are justifiable only when no change has been found in the kidney after microscopic examination. I believe, if sections of whole kidney were made and examined in every case, that the list of undiagnosed cases would become smaller instead of multiplying. This has been demonstrated by Albarran of Paris, who examined a kidney and pronounced it nephritis after it had been examined and reported as essential hematuria.

In new growths the blood is in large quantity, attended by little pain, rarely acute, and not accompanied by pus. Bleeding is usually present for a number of days, and the intervals short. Bleeding from tuberculosis occurs during rest, is not relieved by lying down, and may not be accompanied by pain. The blood is nearly always mixed with some debris.

In a series of 282 cases of tuberculosis collected by Dr. Walker bleeding was a primary symptom in 72 cases and was a secondary symptom in 12 cases. It varies from so small amount as to be demonstrated only by the aid of the microscope up to quantities so large as to endanger life. Hematuria is usually intermittent in renal tuberculosis, several days or months elapsing between the periods of bleeding. The hemorrhage tends to become continuous late in the disease.

Blood from a stone is present during or after an attack of renal colic. Hemorrhage is usually increased by exercise and lessened by rest.

Hematuria from nephritis is usually continuous, often painful, and presents other symptoms of renal disease. Albumen, casts and epithelium are in the urine. It may be bilateral, and may involve only part of the kidney, which latter fact explains its sometimes being overlooked.

Freeman records one case of hematuria due to nephritis, the bleeding being so profuse as to endanger life.

Naunyn reports three cases of profuse hematuria accompanying Bright's disease.

Ransohoff records a case in which hematuria existed for 10 years, and it had been diagnosed successively as cystitis, appendicitis, pyelitis, stone in the kidney and floating kidney. Micturition was frequent and painful, with blood present at each examination. It was diagnosed as stone in the kidney; operation, no stone; section examination showed nephritis; cured.

To sum up, it is shown conclusively that we have great obstacles to overcome in making a diagnosis, more especially between stone, tuberculosis and nephritis. The use of the *x*-ray has done much to help solve the difficulty, but it is not to be relied upon entirely, as it does not show the presence of very small stones. It may give us a negative result when the stone is present. This is not to be wondered at when we consider some of the very small stones that are removed.

Kelly's method of sounding the kidney for stone with a wax-covered urethral bougie has aided us but little on account of the various positions that a stone in the kidney may occupy.

In tuberculosis the only positive evidence is the finding of the bacillus of tuberculosis in the urine. Finding, as we do at times, an absence of all positive signs, the number of operations done for stone and tuberculosis with negative results is not surprising.

The paroxysms of pain seen in tuberculosis or kidney-stone may be present in nephritis, and are caused by the changes that take place in the circulation of the kidney. The cause is obvious when we consider the structure of the fibrous capsule, which is not elastic, and does not give to the rapid distention that takes place in an inflamed kidney.

Hematuria is associated with stone or tuberculosis by most physicians if found in small amounts with absence of albumen or casts. Again, the number of cases of nephritis in which pain is present and albumen and casts absent at intervals, with hematuria, makes the difficulty of diagnosis still more apparent. We have then a change in the structure of the kidney which, in its symptoms, simulates stone or tuberculosis.

Until a short time ago when Naunyn reported his three cases, with many such cases reported since by other men, profuse hematuria was not associated with nephritis. Reports of cases of this character are not numerous, which is my excuse for a report of the following:

Case I.

Fletcher Johnson, negro, 28 years old, laborer, married; residence, Crisfield, Md.

He came to the University Hospital August 18, 1903, complaining of bloody urine and weakness. He had been for some time the hostler for a physician, and had been under rather close observation. It was thought he had a tubercular bladder.

His father and two sisters died of tuberculosis. There is nothing else of interest in the family history. He had mumps, chicken-pox and measles when a child, with no sequelae. No relation between the measles and any kidney trouble could be made out. When 17 years old he had pneumonia, from which he made a good recovery. Since that time he had been perfectly well until the beginning of present trouble.

His habits were good. Prior to beginning of trouble he had drunk moderately of whiskey and beer. He denied the use of any drug, and drinks coffee twice a day. He had always led an active outdoor life.

In January, 1900, he first noticed blood in his urine, and this had grown gradually worse until his coming to the hospital. At that time he was passing clotted blood in large quantities, so that his urine looked rather like blood than urine. There had been no pain during micturition, and micturition had not been difficult until one week before coming to the hospital. He then began to have difficult and painful urination. From the beginning of attack he had pain in the left lumbar region, getting worse all the time.

During the six months previous to his coming to the hospital he had all the symptoms of intense anemia—vertigo, weakness, paleness of mucous membranes and inability to do any work. When first seen he was so weak he could scarcely walk across the ward. His mucous membranes were very pale, his conjunctiva almost pearly in color, and he was passing large quantities of blood in his urine.

His blood examination showed leucocytes, 13,200; red-blood cells, 2,472,000; hemoglobin, 27 per cent. Examination of urine showed a large quantity of red-blood cells, some pus cells, an occasional granular cast, acid with a high specific gravity because of the presence of so much blood in the urine.

Examination of urine for bacillus tuberculosis was negative. The bladder was persistently explored for stone with negative result. On September 12 his hemoglobin was only 25 per cent.

He was put on tincture of chloride of iron, gtts. xx; quinine sulphate, grs. v, and Fowler's solution, gtts. iii, three times a day and kept quietly in bed. From this time he began to improve. On October 1 his hemoglobin was 50 per cent. He was still passing large quantities of blood in his urine, and this was aggravated by his moving about.

On October 15 his ureters were catheterized. Clear urine was gotten from the right ureter and bloody from the left. This showed clearly that whatever was the cause of the hemorrhage it was in the left kidney. An *x*-ray picture was made of the kidney, but no stone made out.

On October 14 the hemoglobin was 70 per cent. On October 22 it was 73 per cent., red-blood cells 4,080,000, and leucocytes 11,000.

A stone of the kidney was suspected in spite of the negative *x*-ray, and operation was advised. He was carefully prepared for operation. Three ounces of whiskey were given in the morning, beginning at 6 A. M. and one-half hour before operation. One-quarter grain morphia sulphate and 1-100 grain atropine sulphate were given hypodermically.

Patient was operated on October 22; anesthetic, nitrous-oxide gas and ether. The anesthetic was taken quietly, and the condition of patient was good during the entire operation.

An incision eight inches long was made over the left kidney, and the kidney exposed and delivered. It was palpated for stone, but none found; then a small incision was made in the kidney and an exploring finger introduced. The most careful search revealed nothing, and the kidney was slowly split open, examining all the while for stone. Finally, the kidney was entirely bisected, exploring the hilum, and a probe introduced into the ureter, which was open. Then each side of kidney was further palpated, but no stone made out.

The kidney was enlarged and injected, and near the upper pole were several small areas, which looked lighter than the surrounding kidney structure and were firmer. A small portion of the kidney structure at this point was removed for microscopical examination. The capsule was adherent above and the entire capsule stripped off. The kidney was sutured completely with catgut, through and through sutures without drainage, the fascia was sutured lightly, then the muscles, both with fine silk, leaving a small drain down to the kidney surface. The skin was closed, except for a small area where the drain was, with a subcutaneous silver-wire suture.

The patient went off the table in good condition. The first urine voided was bloody, the several urinations showed much less blood, and on the afternoon of the day after the operation the urine was clear. There was no recurrence of blood afterward.

The wound healed primarily. There was no leaking of urine. The patient gained rapidly in weight and strength, and was discharged cured. At the present time the patient is perfectly well.

Dr. Hirsh, pathologist of the University of Maryland, reported as follows: The lesions are most marked in the cortex; here the epithelium is considerably swollen, many of the cells show a cloudy swelling, others are granular. Staining with osmic acid fails to show any fatty degeneration. Many of the tubules show red-blood cells and hyaline and granular casts.

The cells of the glomeruli have in places been completely desquamated, and a granular detritus, with a few blood cells, are present in the intracapsular space. Bowman's capsule is here and there thickened. The changes in the interstitial tissue are not well marked; there is a slight increase of connective tissue, and a round cell infiltration in places. Altered blood pigment is present in the interstitial tissue.

Diagnosis: Beginning chronic parenchymatous nephritis with hemorrhage.

Case II.

Girl, 20 years old, on whom I had previously operated for appendicitis, was taken suddenly on the street with colicky pain in the left side. I saw her about 7 P. M., at which time she was in bed, lying drawn almost double and suffering severely. Two grains of morphia were necessary to relieve her pain. She was brought to the hospital the following day and ureters catheterized. The urine from the left kidney showed pus, hyaline casts, kidney epithelium and a small quantity of blood; that from the right contained hyaline casts and kidney epithelium. The urine was scanty in amount.

The temperature ranged from 99° to 101°. Pain was relieved by morphia, and she was put on diuretics. She left the hospital in four weeks much improved. She had a similar attack six weeks afterwards and was brought to the hospital again.

Diagnosis: Stone in left kidney.

Operation: Incision, kidney delivered and examined. It was found enlarged, and at the lower pole there was a band of thickened capsule, which had made its way down into the kidney substance, constricting the lower pole. The capsule was split from pole to pole, dividing the constriction. The capsule above the constriction was normal and not adherent, and the kidney structure appeared normal. The capsule below the constriction was adherent, and there was free bleeding when it was removed. Unfortunately, a piece of kidney was not removed for examination. The fatty capsule was brought over the kidney and the kidney placed in position. The wound was closed without drainage. Patient made a good recovery, and has had no trouble since. A short time ago showed the urine to be normal.

The operation of choice is decapsulation. The manner in which it effects a cure is the relief of tension by division of the capsule, allowing the kidney to expand, and relief of congestion through the formation of a new blood supply with the fatty capsule. Technique of operation: A vertical incision is made through the skin and fat down to first layer of muscles from last rib to within two fingers' breadth of spine along the erector spinal muscle. The latissimus dorsi is drawn aside and the aponeurosis divided, exposing the quadratus lumborum muscle. This is drawn aside, which exposes the transversalis fascia. Division of this to extent of wound will bring the fatty capsule and kidney into view. Now open the fatty capsule and deliver the kidney on the back for examination. The kidney in this position is easily examined by sight and touch.

If nothing is found, the kidney should be incised and a critical search for stone or diseased condition made. Failing in this, a small piece of kidney tissue should be removed for microscopical examination.

The removal of the capsule, allowing the fatty capsule to come in contact with the raw surface of the kidney would, I believe, cure many cases simulating stone or tuberculosis. I strongly advise decapsulation and opening of kidney, with removal of a small section for examination, when hematuria is present with albumen, casts or epithelium of the kidney in the urine, for by so doing a diagnosis can be made and the patient is cured of both hematuria and nephritis.

I am indebted to Drs. Walker and Hundley for the catheterization of the ureters of these patients.

THE UNIVERSITY HOSPITAL.

By Randolph Winslow, M.D.,

Professor of Surgery.

The University of Maryland was one of the first institutions in this country to appreciate the importance of clinical instruction, and in furtherance of that object a lot was secured at the southwest corner of Greene and Lombard streets, and on June 10, 1823, the cornerstone of a hospital was laid, which, when completed, was known as the Baltimore Infirmary. This was the first and for a long time the only general hospital in the city.

By successive additions the capacity of the institution was increased, but the original building continued in existence until it was demolished in 1896, a period of 73 years. During this long term successive generations of eminent physicians and surgeons served the cause of humanity and science within its walls, and successive classes of students received their practical instruction in its wards. Here labored Davidge and Potter, imposing figures in their day; Gibson and Dunglison, who subsequently were called to the University of Pennsylvania and Jefferson Medical College, respectively, and achieved the highest distinction; Nathan R. Smith, familiarly known as the "Emperor," who for a period of nearly 50 years shed luster on the hospital and school by his surgical skill and reputation; William Power and Charles Frick, whose brilliant gifts could only be exercised for a brief period, when at a premature age they fell asleep; the elder Chew, the worthy sire of a worthy son; the courtly McSherry; William A. Hammond, subsequently surgeon-general of the United States Army; Edward Warren, chief of staff to the Khedive of Egypt; Christopher Johnston; Joseph Roby, whose anatomical erudition is still held in high regard by the older physicians of the present day; Julian J. Chisolm, the eminent oculist and teacher; the eloquent and chivalrous Miles; the genial Michael, and many others equally worthy performed their work faithfully within the walls of the old hospital, and having finished their tasks do now rest from their labors. But there are others who also wrought in the old building who still remain with us—venerable men, full of years and honors, whose hoary locks are a crown of glory. Professors Miltenberger and Howard, though retired from some of the activities of professional life, are regarded as the Nestors of the medical profession in this city, and

are held in the highest esteem and reverence by the faculty and alumni of this University. The young-Chew, beloved by his associates and students, still adorns his chair in the medical school, though he has retired from the active clinical work of the hospital. Tiffany, the eminent surgeon, and I. E. Atkinson, the clinician, both learned and taught their art in the old Hospital. But the times changed—"*tempora mutantur, et nos mutamur in illis.*" The old Infirmary had outlived its usefulness, and new conditions confronted us. How shall these be met? On February 6, 1896, the first definite steps were taken in this direction. From the minutes of the Faculty of Physic of that date I make the following extract:

"Professor Winslow moved: 'That a committee of three members of the Faculty be appointed by the Chair, whose duty it shall be to investigate as to the possibility and method of erection of a new hospital, and report to the Faculty upon the subject as soon as possible.' Carried.

"The president appointed the dean (Professor Coale) and Professors Atkinson and Winslow."

This committee reported favorably upon the project and presented a plan of procedure, which was adopted by the Faculty.

The actual work of rebuilding was begun in August, 1896, and was complete in September of the following year. The improvements at that time cost about $100,000, and since then many other thousand dollars have been expended in still further increasing the efficiency of the Hospital. The old name of Baltimore Infirmary permanently disappeared from the buildings, and that of University Hospital was graven over the imposing portal of the new structure. In mentioning those connected with the erection of the new University Hospital it would be invidious to omit the names of Dr. St. Clair Spruill, medical superintendent, and Miss Janet Hale, superintendent of nurses, to whose active and intelligent co-operation much of the success of the undertaking is due. Time does not permit me to mention more fully the strenuous efforts by means of which the Hospital continued to do its beneficent work whilst the buildings were being demolished and re-erected. In September, 1897, the new building was occupied, and at once entered upon an era of greatly-increased activity and usefulness, which has progressed from year to year until the present time. I will not tire you with a description of the new University Hospital—you know it well. I will say, however, that, in the opinion of the writer, the erection of the new Hospital has not only been of great service from a humanitarian standpoint, but, by increasing the facilities for clinical teaching, has added much to the popularity and reputation of the School of Medicine. Let us all strive—those of us who have reached the meridian of life and upon whom the rays of the setting sun are cast, as well as those of you whose faces are toward the sunrise—to so work for the good of our fellow-man and the glory of God that at last we also may rest from our labors and may receive the blessed benediction, "Well done, good and faithful servant. Inasmuch as ye have done it unto one of the least of these My brethren, ye have done it unto Me."

PENETRATING WOUNDS OF THE THORAX.

By Nathan Winslow, M.D.,

Assistant Demonstrator of Anatomy, University of Maryland.

Owing to the oftentimes serious results incident to penetrating wounds of the thorax, whether due to bullet, knife or other instrument, it is well that we should not only be able to recognize the extent of the injury, but also be cognizant of the proper treatment.

In an injury of this character the thoracic viscera may or may not be involved. In rarer instances, if the wound is below the fifth rib, not only the pleural cavity is entered, but the weapon or bullet may also pass through the diaphragm into the peritoneal cavity and spend its fury by lacerating abdominal viscera, thus adding a serious complication to an already grave injury.

Among the foremost complications in a penetrating wound of the chest with which we have to cope is hemorrhage originating from a lacerated intercostal or internal mammary artery. Severe, and in most instances fatal, bleeding follows laceration of the heart and the large vessels, both veins and arteries, of the thorax. If the lung is ruptured, pneumonia, gangrene, abscess or an uncontrollable oozing may ensue. As a consequence of the penetrating object being contaminated with pathogenic germs, even if there is no injury to the viscera, an empyema often is a sequel. When the peritoneal cavity is involved peritonitis follows. Especially is this true in cases where the abdominal viscera are also perforated. Among the remote dangers may be mentioned wounds of the esophagus, spinal cord, thoracic duct and phrenic nerve.

The symptoms vary with the extent of the injury. The physician will elicit the history of a gunshot, stiletto or other instrumental wound of the thorax. The patient is more or less shocked, the pulse is rapid, the temperature is elevated, the respirations are shallow, pain is present at the seat of injury, the skin is clammy, and the features have an anxious expression. A frequent symptom is hemorrhage from the external wound. The presence of emphysema in the surrounding tissues is a sure sign the pleural cavity has been entered; and blood forced out of the external wound during coughing spells is just as good an index of penetration of the thoracic wall. If the lung is hurt, the patient expectorates a bloody mucus during paroxysmal spells of coughing, and during the respiratory excussions there is a hissing noise, due to the air being forced through the external wound. In some instances the hemorrhage empties into the pleural cavity, giving rise to dulness on percussion, together with the other signs of fluid in the thorax. Pneumothorax, a frequent result of these injuries, if very extensive, may cause collapse of the lung upon the affected side. In such cases the percussion note is amphoric in character, and the breath sounds are entirely or partially absent. Occasionally in large wounds there is a partial protrusion of the lung.

There are no hard and fast lines laid down for the treatment of these cases, but each one has to be managed according to the structures involved. If there is no hemorrhage, and the wound is small, clean the surrounding parts and dress antiseptically; then put the patient to bed and keep him quiet with opiates if necessary. As an infection might be set up, in no event probe for the bullet. If quite an extensive laceration has been inflicted, after all dirt and ragged tissue have been thoroughly removed, pack it with sterile gauze. Our first aim should be the stoppage of hemorrhage, no matter whence it originates. If from an intercostal vessel, ligate; whenever necessary enlarge the wound. In hemothorax the pressure of the effused blood might be sufficient to check the flow. In this event, however, quite a time is required for its absorption, besides suppuration might occur; so the best treatment is a rib resection and drainage with a rubber tube and gauze. In emphysema the air is gradually absorbed. Pneumonia is handled as if it occurred without an injury. If empyema, gangrene or abscess of the lung supervene, a rib resection and drainage are imperative. When the peritoneum is injured a laparotomy is necessary. In case the heart or large vessels are badly damaged, operative intervention is of no avail. Once in a while the heart has been sutured after slight lacerations.

The medicinal treatment is to keep the patient quiet with sedatives if necessary. Stimulate with strychnine, whiskey, normal salt solution, carbonate of ammonia, and give liquid diet.

THE URINE IN HEPATIC DISEASE.

By Hubert Richardson, M.D.,

Late Pathologist to Mount Hope Retreat; Pathologist to Maryland Asylum and Training School for Feeble-Minded Children; Demonstrator of Physiologic Chemistry, University of Maryland.

The importance of the liver to the metabolic processes cannot be overestimated, and is demonstrated by the rapidity with which all animals die when it is cut off from the circulation.

One of the functions of the liver is the formation of urea as an end product of metabolism preparatory to its elimination by the kidneys. If this function is impaired, the intermediatory bodies will be eliminated in the urine. Among these ammonia is of great diagnostic importance. Under normal conditions about 87 per cent. of the nitrogen is eliminated as urea, 4 per cent. as ammonia, 1 per cent. as uric acid, and about 8 per cent. as extractives. A decrease in the amount of urea nitrogen with an increase in the ammonia nitrogen points to an hepatic insufficiency.

The uric acid eliminated is partly taken with the food, exogenous uric acid, and partly formed from the nucleins of the body cells, endogenous uric acid. The liver has the power of converting a certain amount of uric acid into urea, so that if the uric-acid nitrogen eliminated is increased, with a decrease of the urea nitrogen, it is presumable that the liver function is impaired.

The ammonia eliminated in the urine is combined with an acid, it being this substance which prevents the acids formed in metabolism or ingested from rendering the blood plasma acid. The acids with which ammonia is combined as an intermediatory body are lactic and carbonic acid. The presence of lactic acid in the urine, with a decrease of urea nitrogen, is diagnostic of impaired hepatic function. The presence in the urine of bile pigment, even in traces, is diagnostic of hepatic cirrhosis even in the very early stages of the disease. As the disease advances the urine

becomes darker in color, owing to the presence of urobilin. The laboratory test for bile pigment is simple. In a test tube place a small quantity of the urine to be tested and pour some tincture of iodine which has been diluted with 10 volumes of 95 per cent. alcohol on the surface. At the point of contact a green zone will form if bile pigment be present. To test for urobilin, saturate about 50 c. cm. of the urine with ammonium sulphate. filter, wash the precipitate with saturated solution of ammonium sulphate; then wash the filter with 95 per cent. alcohol. If urobilin be present, the alcoholic washing will be of a brown tinge.

Leucin and tyrosin crystals in the sediment, with excess of phosphates and of neutral sulphur, denote hepatic disease.

In hepatic insufficiency hypoazoturia is the rule. The urea nitrogen may be as low as 70 per cent. A case is on record where it fell to 40 per cent. of the total nitrogen. The ammonia N. may rise to 8 or 10 per cent. and the uric-acid nitrogen increase to 2 or 3 per cent.; the extractive nitrogen is increased. The carbon elimination is reduced, as is also the neutral sulphur indicanuria, urobilinuria. The presence of bile pigments and urobilin are definite diagnostic symptoms.

The urine abnormalities in the more common affections of the liver are as follows:

Congestion of the Liver.—The urine is diminished in quantity; the specific gravity increased; the color dark red, due to the presence of bile pigments and urobilin; the total nitrogen is decreased; uric acid increased, as are also the chlorides; the elimination of phosphates is very much increased—cases are on record where they have been seven times the normal.

Alcoholic Atrophic Cirrhosis.—There is an inversion of the rhythme in the elimination of the urine. Under normal condition there is more urine secreted during the day than during the night, and for two hours after meals the secretion is greater than at other times. In this form of cirrhosis there is more urine secreted during the night than the day, and the secretion during the two hours after meals is less than at other times, showing that there is portal hypertension. The acidity of the urine is increased; the color dark; urea N. decreased; uric acid N. increased; ammonium N. increased; phosphates increased; chlorides diminished; carbon increased; tyrosin, leucin, albumen, peptone and glucose may be present; urobilin is constant.

Alcoholic Hypertrophic Cirrhosis.—The urine is the same as in the atrophic form, only the variations are not so marked.

Hypertrophic Cirrhosis with Chronic Icterus (Hanot's Disease).—In this disease the bile pigments and urobilin appear in the urine in greater quantities than in the foregoing diseases, bile pigment occurring in the plasma and in some cases in the cerebro-spinal fluid.

Icterus Gravis.—The volume of the urine is decreased 250 to 800 c. cm.; the specific gravity high; color brown red, yellow in the early stage; urea decreases; uric acid increases; the elimination of inorganic salts is decreased; leucin, tyrosin, xanthin and hypozanthin are increased; casts, albumen, peptone, bile pigments and urobilin are present; lipuria has been observed.

A careful examination of the urine enables us to detect hepatic insufficiency in its very early stages when it is possible to arrest its progress, thus preventing the renal trouble which must of necessity be a sequence to hepatic disease, the kidney being called upon to excrete substances for which it has not been adapted by nature.

ABSTRACTS AND EXTRACTS

Ten Years' Experience With Diphtheria Antitoxin.—Dr. William T. Watson (1891) in the *Alumni Journal of the Baltimore Medical College* for April, 1905, reviews the results of the use of the antitoxin since it was first procurable in the United States, now exactly 10 years. Whereas the mortality was formerly about 42 per cent., the statistics of our large cities now show 6-12 per cent. mortality. In laryngeal involvement requiring intubation the mortality has fallen from 75 to 25 per cent. The number of cases requiring intubation has also diminished. The early use of antitoxin in the primary infection will prevent the laryngeal involvement. Dr. Watson has used antitoxin in 159 non-operative cases, all neglected cases. The mortality was 3.8 per cent. Properly cared for it would probably have been *nil.* A synopsis of these cases is given. One hundred laryngeal cases have been operated on in which antitoxin was administered, with 78 recoveries and 22 deaths. These figures would probably have been reversed in pre-antitoxin days. Many of the fatal ones were almost beyond hope when first seen. Of cases seen in the practice of others (81), 23.5 per cent. died; of his own 19, 15.8 per cent. died. Sixty per cent. of the deaths occurred in the one-fourth under two years of age. Antitoxin was used for immuniza-

tion in over 300 cases, and in none of these did diphtheria develop.

Dr. W. then contrasts former with present treatment, the first agreeing in the main in the necessity of *very frequent* local and internal medication of antiseptics. Nowadays at the earliest period, while awaiting the results of a culture, the physician administers antitoxin and thus gets control of the case from the beginning. The membrane usually soon disappears, and in a week the child resumes its ordinary mode of life. Aside from the decrease in mortality, antitoxin saves the little patient a vast amount of suffering, the attendants an equal amount of worry and work, and the parents a great deal of anxiety and expense. All children who are exposed should be promptly immunized. Statistics were given showing the advantage of early administration, as, *e. g.*, of cases treated on the first day .34 per cent., whilst of those treated after the fourth 23.1 per cent. died. The remedy is harmless, but it is expensive, and enormous doses are not called for. The doses recommended by Holt probably meet the views of the best authorities, viz., under two years 2000 to 3000 units; over two years, mild cases, 2000 to 3000 units; severe cases, 4000 to 5000 units; exceptionally severe cases, 8000 to 10,000 units. Repeat in six to eight hours if no improvement be seen. [For Dr. Watson's experience in intubation see BULLETIN for May.]

A CASE OF TETANUS TREATED BY ANTITOXIN.—At the recent meeting of the Medical and Chirurgical Faculty of Maryland Dr. C. F. Davidson (1888) reported the case of a boy aged 12, who had a severe attack of cellulitis of the scalp and left arm, requiring free opening and drainage. About 12 days after the beginning of symptoms he began to have tetanic twitchings, especially about the mouth. Nine convulsions occurred in the next 24 hours, when the antitoxin arrived and was administered in 20-centimeter doses every four hours, as directed on the bottle. This was continued 40 hours, during which there were seven convulsions. The patient appearing to get worse, and an unusually severe convulsion seizing him, and his life being despaired of, 60 centimeters were given and an hour later 40 centimeters more. In one hour the convulsions ceased and the temperature had fallen from 107.4° to 100°. Four hours later the last dose was given and there were no more convulsions, but steady recovery resulted. The boy was exhibited. Dr. Davidson thought in another similar case he would give at once 100 centimeters of the antitoxin.

THE INTRODUCTION OF CLINICAL TEACHING OF OBSTETRICS IN THE UNITED STATES.—In an interesting article in the *American Journal of Obstetrics* Dr. John Whitridge Williams (1888) draws attention to the services of the late Dr. James P. White of Buffalo in introducing the public teaching of clinical obstetrics into the schools of America. It was on January 18, 1850, that he did this before his class at the University of Buffalo, an Irish girl being delivered in his clinic of her second child. At the time of labor the students, 20 in number, were brought in one by one and allowed to make an examination, while at the end of the second stage all were called. The patient was placed upon her left side and the bedclothes drawn back so as to expose the genitalia and buttocks during the delivery. This was regarded as a startling innovation, the medical profession and the public being divided as to its advisability and morality. The sentiment against Dr. White, fostered by certain physicians, culminated in a letter in the *Buffalo Courier* signed "L," so venomous in character that he was compelled to institute a suit for libel against its author. In this letter the author spoke of the "gross outrage upon public decency," of the "meretricious curiosity" and "salacious stare" of the onlookers, charging that the affair was an attempt "to build up for someone a reputation," and asserting that "no school on the face of the earth ever tolerated a like exhibition." In the *Buffalo Medical Journal* for March, 1850, appeared a letter signed by 17 of the 40 physicians of Buffalo, asserting that the exhibition was "wholly unnecessary," "unprofessional in manner and grossly offensive alike to morality and common decency." This letter was republished by the *Christian Advocate* with so severe an editorial that Dr. White felt called upon to have its editor also indicted for criminal libel. The case now became of national interest, and the profession and medical journals generally sustained Dr. White. The first trial resulted in the acquittal of the defendant, who it was proved had not written the letter. The *American Journal of the Medical Sciences* condemned the act of Dr. White in editorials, and said that was the unanimous sentiment of the Philadelphia profession and apparently of a large majority of the profession of the United States. A committee of the American Medical Associa-

tion to whom the matter was referred for report, while holding that it was not immoral or wrong, declared it "entirely unnecessary for purposes of instruction." However, Dr. White's ideas have now gained acceptance, the method being in general use in every lying-in hospital in the country. Dr. Williams attributes the low grade of obstetrical technique so long characterizing American medicine, and the claim of doctors that they rarely had a tear, to the opposition of medical men to the ocular conduct of labor. There was also much neglect of the teaching of obstetrics and much prejudice against "men midwives" up to 1850, and it was looked upon as a somewhat demeaning occupation, and hence was carried out in a perfunctory manner, without interest and accurate observation.

The Gavin Operating-Room Basin.—This appliance, devised by Dr. F. D. Gavin (1874), Superintendent of the Church Home and Infirmary, Baltimore, has been in satisfactory use in that institution for eight years. A description and cut of it are given in the *Journal of the American Medical Association* of May 13. It consists of a frame which fits into the usual rectangular basin sink. This frame is composed of silver-plated tubing about three-eighths of an inch in diameter. Occupying the center of the frame is a circular opening, into which an ordinary porcelain basin can be placed. The ring that supports the basin revolves from right to left through a quarter of a circle. It is easily emptied while the hands are in it, being easily tilted by the left, while the right prevents it going too far. The lever principle is employed, the axis, or revolving point, being two-thirds of the distance toward the left of the circle. Its advantages are: 1. It is very simple and cheap; 2. If out of order, any machinist can repair it; 3. It will accommodate a simple porcelain basin that can be purchased in any hardware store; 4. The frame and basin can readily be placed in the sterilizer and steamed; 5. Fresh basins can be used for each operation. Frame and basin should not cost over $5.

Treatment of Epilepsy.—I wish to emphasize the fact that the medicinal treatment of the convulsions forms only one item in the treatment. To my mind the most satisfactory management is that which is carried out in special institutions or under the care of a well-trained and sensible nurse attendant. In this way only can the patient be guided along hygienic lines in respect of the suitable quantity and quality of food, the proper allotment of work and rest, and the carrying out of those physical exercises consistent with the malady. Epileptics suffer notoriously from lowered vitality and sluggish circulation in the extremities, for which warm baths, spinal douches and massage are important remedial agents. In the treatment of epilepsy, therefore, there has ever to be kept in mind the persistent character of the malady and the tendency towards mental deterioration. As important as therapeutic remedies are congenial employment, hygienic modes of life and suitable amusements.—*W. A. Turner, Lancet.* March 18, 1905.

PERSONAL MENTION OF ALUMNI.

Dr. J. Wann McSherry of the class of 1855 has practiced his profession for the last 40 years in Martinsburg, W. Va. Dr. McSherry has been a most useful man in his community and one of the most distinguished physicians in his State. He is a most genial gentleman and sincere friend. In his pleasant home he and his accomplished wife are noted for their hospitality and charity. Dr. McSherry is a most loyal friend to his old Alma Mater, and never loses an occasion to attend the annual meetings of the Alumni Association when circumstances admit of his being present. Although he has reached an age when retirement from professional work might be claimed by reason of long service and financial success, he continues to work for his old patients and for those who need his charity. Few men have lived to better purpose and are more beloved than this accomplished physician and gentleman.

Dr. E. L. Sincindiver of the class of 1891 is one of the most successful of the younger physicians of Martinsburg, W. Va. He has already taken a high position in his profession and has a promising future before him. The doctor is an occasional visitor to the University Hospital and to the annual meetings of the Alumni Association.

Dr. W. H. Marsh of the class of 1876 has practiced his profession for many years on Solomon's Island, Maryland. For some years he has been local surgeon for the Marine Hospital Service, which has established a small hospital on the Island for the sailors of the Chesapeake. Dr. Marsh is the only physician living on the Island,

and in his somewhat isolated position has to assume responsibilities not usual to physicians who can call on their associates in times of emergency. He is the right man for the place, as has been shown by his long stay in the Marine Hospital Service. Now and then the doctor is a visitor to some of his old friends in Baltimore, who enjoy his genial, sunny presence and picturesque accounts of the novel life he leads on an island in the Chesapeake, the rendezvous of the men who make their living in an atmosphere of oysters, fish and crabs. It is a real pleasure to those of us who live in a large city to come in contact with men who have about them the freshness of nature and a love for a seafaring life.

Dr. J. E. Bromwell of the class of 1861 has practiced medicine since date of graduation in Mt. Airy, Carroll county, Maryland, where he has led a most active and useful life in his profession, combining with it a love for rural interests, a devotion to good horses and dogs and those side issues which go so far to make the life of a country practitioner enjoyable as well as useful to the people he serves. For one who has worked so hard as a country practitioner few have had the faculty of getting more genuine satisfaction out of his work than Dr. Bromwell. Keeping pace with the best medical literature through the medium of a modern library, he has been able to do the very best work for the people who have employed him. He is a frequent visitor to the large cities, especially Baltimore and Washington, and in this way is kept abreast with the progress of his profession.

Among the most successful of the alumni of the University practicing in this State is Dr. L. C. Carrico of the class of 1885. Dr. Carrico has practiced in Charles county, Maryland, since date of graduation with distinguished success, and is one of the most prominent physicians in lower Maryland. He has the entire confidence of the people of his section, as has been shown by the fact that he has represented his county in the legislature and in the senate of Maryland, where his services were of a most valuable character. He has always been a warm friend of the University and has rendered her noble service in securing State aid when it has been asked for. He has also rendered the profession of the State valuable service when matters of legislation have been brought to the attention of our lawmakers at Annapolis. Dr. Carrico has served his county at Annapolis at a personal disadvantage. It is fortunate that men of his capacity are willing to make such sacrifices for the good of the people among whom they live. It is to be regretted that men of the medical profession cannot represent the people more frequently in public office without sacrificing their professional interests and impairing to some extent their professional usefulness. The prevalent idea that a physician should not hold public office is an erroneous one. No class of men, as a rule, are better qualified to promote good citizenship and to lead the public along lines of good civil government than well-educated physicians. When members of the medical profession are willing to lay aside the active practice of their profession for a season and to serve in public office this sacrifice should be recognized and commended by their colleagues. The profession of this State needs more such men in the legislature and senate as Dr. Carrico.

Dr. J. C. Clark of the class of 1880, is an alumnus of the University who has risen with rapid strides to the front rank of his special line of professional work. After graduation Dr. Clark began the practice of his profession in one of the Eastern Shore counties in Maryland. The people of his county, recognizing his worth as a citizen, elected him to the house of representatives, where he rendered conspicuous services which secured him an appointment as assistant physician to the Maryland Hospital for the Insane. After the new hospital was opened at Sykesville under the superintendency of the late Dr. Rohé of the class of 1873, Dr. Clark was appointed an assistant in the new institution. After the death of Dr. Rohé, Dr. Clark was elected to fill the place made vacant by the loss of this accomplished physician and alienist. Dr. Rohé had, in the few years he was in charge of Springfield Asylum, inaugurated a system and developed a work which was revolutionary in its benefits to the insane of this State. Dr. Clark took up the work where Dr. Rohé had left it off, and has brought the Springfield Asylum into the front rank of institutions of its character. He has shown administrative and medical talents of high order, and has already taken a conspicuous place among the alienists of this country. Dr. Clark has recently returned from a trip to Europe, where he went to look into the methods of work employed in the management of the insane in foreign countries. Dr. Clark is professor of psychiatry in the Woman's Medical College of Baltimore.

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EDITORIAL

THE OPPENHEIMER INSTITUTE. — The editor was lately visited by a gentleman representing himself as the agent of this concern and claiming to be both physician and clergyman, who desired to secure his services as representative in this city. The business advantages were, of course, presented in the strongest light, and extraordinary claims were put forth regarding the miraculous effects of the remedy which, according to the statements of the visitor, constituted the sole agent in the treatment. This remedy is known as "noctarine," and its mode of preparation and ingredients are not divulged. It is to be administered three times a day at first, then twice a day, then less often through a period of three or four weeks. The effect is said to be evident at once in an invincible repugnance to all alcoholic liquors, which have no further attraction for the sufferer. It is attributed to the tonic and stimulant properties of the remedy, which replace those of the alcohol. It is not narcotic. The visitor further showed a list of Baltimore physicians with whom he said the Institute had been in correspondence. It did not take long for us to decide as to the proper course of action. The position into which it was sought to induce us to enter was nothing less than that of catspaw to Dr. Oppenheimer and his agent. Our good name and reputation were to be given away for a consideration. We were to be used as the tool for the introduction into this community of a secret remedy, that is, of a quack remedy, for all secret remedies are quack remedies. As we learn from another source, the charge allowed for the treatment of each case is $150, of which $100 goes to the physician and $50 to the Institute. There may be those who will be induced by avarice or necessity to desire to secure this position. But any independent man who values his own self-respect and the honor and dignity of his profession will hardly connect himself with this concern if he understands it. It is not the doubtful class, those of small repute, they want, but it is the man of established reputation and high standing, one who can, by his connection with it, confer upon it at once the glamor of respectability, of charity, for that feature is also brought in, and of conformability to professional ethics. Two suspicious facts are at once apparent—one that a preacher is advocating it, preachers being notoriously the friends of all sorts of quackery; another that among the directors the name of but one physician is given besides that of the projector. We can, therefore, only express the hope that none of the graduates of this University will so far forget themselves as to be led into such an association as this Oppenheimer Institute has sought to form with the writer. Among the names of correspondents we noted several "Maryland" men.

THE MEDICAL STANDARD.—Under the continual agitation of the subject by the American Medical Association, the Association of American Medical Colleges and the State Examining Boards, backed strongly by the sentiment of the profession at large, there is no doubt that the standard of attainments required by the graduate of medicine is slowly but steadily rising. Every true and disinterested friend of the medical profession in this country will rejoice at this. The old methods were an incubus from which we escaped only after decades of floundering in the mire amid what seemed to many a hopeless struggle. That there is still much to be done, that we are still far from our ideal, is sadly apparent. There are, for instance, the questions of preliminary acquirements, of a uniform curriculum, of minimum requirements, of reciprocation by the various State boards, of the determination of college standing, still requiring solution and answer at our hands. That a certain fitness in the entering student is needed all must agree. Who shall determine this fitness? Shall it be left to the faculties eager to procure students and pecuniarily interested in their admission, or shall it be entrusted to some independent and impartial board, as, for example, the State Examining Board? What shall be the minimum to which all shall be made to conform? What uniformity is attainable in order that there may be a mutual recognition among the various

boards, a thing so very natural and just? How shall the standing of colleges be determined—by what inspection—carried out by whom? The answers to these and other similar questions must come before long, and while there will always be found a way to evade written rules and regulations, their tendency will still be to raise the standard along the whole line.

It is of interest in this connection to know that at its meeting, held in Chicago April 10, the Association of American Medical Colleges adopted a scheme for national uniformity of curricula. This scheme provides for a 4000-hour course in 27 branches. The two Boards of State Medical Examiners and Licensers had already adopted in 1904 a 3600 and 4000-hour course, respectively. It only remains now to meet and agree upon a course which shall meet the views of the various societies interested, with which, doubtless, the colleges will readily conform, at least in appearance. There should be a uniform standard in this country for *all* schools, and we should hear no more of schools for the "cross-roads doctor" and schools for those who are to teach and investigate. The object of undergraduate work is not to make specialists, but to fit men and women to practice medicine and surgery generally. Schools engaged in turning out specialists and teachers—in other words, graduate work—can have their special curricula to suit their needs. One of the most important considerations in connection with this whole subject is inspection. Nothing is so well known in connection with American medical education as the variability of medical schools. Whilst some are equal to the best of those of Europe, others are a disgrace to our Western civilization. To show up these latter amid their claims and protestations is a necessary step to reform. As *American Medicine* truly says, there are colleges "which, because of lack of facilities or of teaching talent, could not properly prepare men to practice medicine if they had a curriculum of twice 4000 hours." Hence the proposal made by the Maryland Board of Medical Examiners at the recent meeting of the Medical and Chirurgical Faculty in this city appeals to us with irrefutable force.

Shorthand for the Doctor.—Every medical student who has tried to take down the lectures of his teacher realizes the difficulty of doing this fully and satisfactorily. Many of his notes are illegible, he is uncertain about their accuracy, and in a large proportion of cases they are not considered worth transcribing, but are relegated with other trash to the wastebasket. But in the effort to secure the words or ideas of his teacher his mind has been diverted, he has been unable to concentrate his attention upon the subjects treated of, and the time has thus been to him a dead loss. How many of us have wished, under these circumstances, that we were master of some system of shorthand that we might preserve the exact language of our instructors in whom we feel such entire confidence! It is not only during student life, however, that the medical man experiences the need of this useful accomplishment. All through one's professional career it is helpful—indeed, it appears to those who have mastered it almost essential. Sometimes we listen to an address, a discussion, a sermon, or in our reading we find a passage from which we wish to preserve extracts. How easy it appears to note down upon any bit of paper the words in the curious little lines and dots of shorthand and put them aside for use without even the necessity of copying them.

The following affords an illustration of the way in which shorthand may be of the most practical benefit to the physician. A colleague, a specialist in diseases of the eye and ear, who is well known for his skill in this field, tells us that he makes constant use of it in preserving clinical records of his cases. A patient is giving a history of his case; the doctor appears to be toying with his pencil, but really he is noting down what the patient says in shorthand, and later he files away the slip of paper for future use and reference, and thus with no loss of time he is able to keep very complete histories of his cases—much more complete and accurate than he could do in any other way, for he has the exact words of his patients. It appears, then, well worth the while to acquire this useful art in early life, and time is well spent in its acquisition. It is not easy to master, as one so often hears; it requires months, if not years, of practice to make one perfect, and it taxes one's perseverance immensely. Few will persevere at it when begun, and few become so practiced that it is rendered easy to them. Still, to these few it is a welcome and valuable gift, and they feel well repaid for the labor and time spent upon it. There is a society in London devoted to the propagation of this art among students, and Sir William Gowers, the distinguished neurologist, is one of its most ardent advocates.

NOTES AND ITEMS

Dr. Hugh W. Brent, first assistant resident gynecologist in the University during the past year, and Dr. E. Hanson, assistant resident surgeon, severed their connection with the Hospital on June 1, and will go abroad during the summer months for a visit to Denmark, Norway and Sweden. After returning to this country Dr. Brent will locate in this city and Dr. Hanson will locate in New York. Both of these young men have done most efficient service in the Hospital and are well equipped for the practice of their profession. The BULLETIN wishes them success.

Dr. A. L. Wilkinson, assistant resident gynecologist to the University Hospital for the past 10 months, has been elected resident physician to the Hebrew Hospital in this city. Dr. Wilkinson entered upon his new duties on June 1. The Hebrew Hospital is fortunate in securing the services of a man so well trained and so attentive to all duties as the doctor has been during his connection with the University Hospital. He has a most promising future ahead of him in his profession if he continues to live up to the record he has made since graduation. The University is proud of its graduates and rejoices in their advancement.

Drs. W. A. Scott and A. B. Lennan, resident surgeons in the University Hospital during the past year, will engage in private practice in this city. Both of these gentlemen have made creditable records in their hospital work and have shown themselves to be men of sterling qualities and of first-class abilities. With the training they have had they are fully equipped for professional service. Both of them have contributed papers to the BULLETIN, and it is hoped that they will continue their literary ventures. The BULLETIN will gladly welcome articles from all of the graduates of the University, whether connected with the Hospital or engaged in practice in other fields. We ask that this purpose of the BULLETIN be kept in mind by all of the alumni of the University.

On the first of June there was a general leave-taking of the internes of last year and a beginning of work by the men appointed for the ensuing year. This is always a time of commotion and for a general disturbance in the clinical work of the Hospital. To part with men who have been trained for efficient work and to break in new men is a severe ordeal on the working staff. For a time the Hospital machinery runs with friction, but within a few weeks the new order moves along as if nothing had happened. To those of the Hospital staff who remain on from year to year this annual break in the work brings many regrets, since it severs relations with young men who have endeared themselves to those in charge of the various departments by faithful service and courteous attentions. Were it not for the life-long friendships which grow out of these relations between teacher and student, between seniors and juniors, these partings would occasion lasting sorrows. Compensations soon come to reconcile the men who stay and the men who leave. Personal associations may be interrupted, but friendships linger on. The men who go away carry with them, we hope, pleasant recollections of Hospital work and associations, whilst those who stay are always glad to see a familiar face again, to hear of professional successes or an occasional word of gossip about those who have made places for themselves in other fields of work.

There has been a larger number of applications for the position of interne in the Hospital this year than in previous years. The demand for this method of instruction is on the increase, and it is a most encouraging indication of the value of clinical instruction in the training of the medical student. The time is fast approaching when every graduate of a medical school will be required to spend his fourth year in the Hospital. Provision must be made for men who seek this privilege. The University of Maryland has long ago recognized this fact, and no man who is deserving of the appointment as an interne is refused a place in the Hospital. Restrictions must necessarily be thrown around such appointments. Only men who have passed their third-year branches are fully qualified for an interneship. The duties of an interne prevent him from theoretical study. He must give his time to the clinical study of disease and to bedside study, note-taking and to medical and surgical clinics. If his third-year work is behind, he cannot give proper attention to his fourth-year branches. He is an exceptional man who can carry on two years' work in one year's time. We advise students who are back in their work not to apply for the interne position until they have passed all of their third-year work.

The new accident-room recently completed in

connection with the University Hospital is a model of its class, and has been constructed and equipped for the management of all accident cases sent to the Hospital before assigning them to the wards. It has a handsomely-tiled floor and marble wainscoting, a sterilizing apparatus and such other appliances as will facilitate the easy and rapid treatment of all classes of accidents. During the recent accident on the United Railways 24 accident cases were handled in this accident-room by the Hospital staff within two hours' time—a record hard to beat when the hour of the night and character of the injuries treated are considered. The room is located on the ground floor at the north end of the porch recently built in connection with the Greene-street wing.

Dr. J. Dawson Reeder, class of 1903, will be married to Miss Albina Cooke of Green Spring Valley, Maryland, on June 28. Dr. Reeder is connected with the Dispensary of the University Hospital and is one of the promising young physicians of this city. The BULLETIN wishes that his matrimonial future may be as successful and satisfactory as his professional carecr has been and promises to be.

The following named physicians have been recent visitors to the University Hospital:

C. R. Foutz, Westminster, Md.
G. C. Winterson, New Windsor, Md.
J. R. S. Martin, Christiana, Pa.
J. L. Hanes, Winston, N. C.
P. R. Fisher, Denton, Md.
H. E. McConnell, Chester, S. C.
A. W. Nelson, Battle Creek, Mich.
O. S. Gribble, Elkins, W. Va.
J. E. Deets, Clarksburg, Md.
S. R. Donahoe, Jr., Alexandria, Va.
H. E. Clemson, Port Deposit, Md.
N. E. Sartorius, Tangier Island, Va.
A. C. Byers, Lacy Springs, Va.
George Wells, Annapolis, Md.
J. W. Lacy, Lisbon, Md.

Fifty-eight students gradnated LL.B. in the Law School June 5th. The address was delivered by Mr. George Whitelock (1875). The examination prize ($100) was won by Emory Lee Stinchcomb (97.68); the thesis prize, "The Extent of Equitable Jurisdiction in Strikes and Lockouts," by Israel Benjamin Brodie.

A conference on State University was held June 5th at the Governor's office in Baltimore. There were representatives from this University, St. John's and the Agricultural College—fifteen in all. A committee was appointed to consider the feasibility of a plan and ascertain the sentiment of the governing boards thereon. A second meeting will be held in August.

Albert H. Dickinson, M. D. (1856), died in Baltimore, May 23, aged 74.

Subscriptions to the Endowment Fund have been received as follows: Joseph Friedenwald, $100; Douglas H. Gordon, Michael Jenkins, each $50; Charles E. Sadtler, $25; Jenkins Bros., Joel Gutman, each $10; Andrew D. Jones, Mrs. M. B. Billingslea, each $5.

The students' year book is handsomely gotten up. Dr. R. C. Carroll, chief editor. It is 100 pages larger than in 1904. It bears the new name "Terra Mariæ." It is dedicated to Professor Charles Caspari, Dean of the School of Pharmacy.

Dr. Chas. F. Bevan (1871), has been elected Dean of the College of Physicians and Surgeons of Baltimore, vice Thomas Opie, resigned.

A monument was erected to the memory of Dr. Charles H. Ohr (1834), by the Masons of Maryland, May 16, at Cumberland. Dr. Ohr was a Past Grand Master and died in 1903, aged 92.

Dr. Richard H. eLwis (1871), of Raleigh, N. C., was elected president, and Dr. John S. Fulton (1881), of Baltimore, was elected secretary of the Conference of State and Provincial Boards of Health of North America, last month in Washington.

A committee of five has been appointed by the general Alumni Association to prepare for a suitable celebration of the centennial in 1907 by that body.

Dr. A. D. McConachie (1890) has been appointed consulting ophthalmic surgeon at the Church Home and Infirmary, vice Russell Murdoch, M. D., deceased.

Dr. Thomas C. Baldwin, formerly of Baltimore county, is practicing in York, Pa., and is Health Commissioner of that city, and of West York and Spring Garden township.

The Board of Medical Examiners of Maryland holds its spring examination in Baltimore, June 21–24.

The University Football Team under Mr. H. P. Hill, manager, has prepared a schedule for next season embracing a Northern trip, and games with some of the large Northern Universities.

The School of Pharmacy graduated nineteen on May 13. The Dean, Charles Caspari, Jr., received from the University, the honorary degree of Phar. D., and at the Alumni meeting was given a handsome silver service by his colleagues and students.

Dr. Howard Armstrong of the class of 1899 is practicing his profession in Rockingham county, Va., with encouraging success for a beginner. The doctor was a recent visitor to this city and from his healthful appearance he gives evidence that the practice of medicine in the country agrees with him. His post office is Edom.

The Faculty of Physic of the University of Maryland is negotiating for the purchase of the house and lot No. 621 W. Lombard street. This property is adjacent to the two lots now owned by the University and attached to the Hospital on the west. By acquiring this lot the Faculty will own three houses fronting 100 feet on Lombard street and extending back 173 feet to King street. This will make a most valuable addition to the Hospital property and will provide for future developments of the Hospital which must come in time with the constant growth of the institution. In matter of fact the Hospital is already overcrowded with work, and the day is not distant when additional space will be necessary for the accommodation of patients and employees.

At a recent meeting of the Faculty of Physic Mr. H. Busick and Dr. A. M. Shipley were reelected to the positions of General Superintendent and Medical Superintendent of the Hospital for the fiscal year beginning July 1. Under the management of these two gentlemen the work of the Hospital for the past year has been eminently satisfactory. The condition of the Hospital, its conduct and its financial status have never been better than at the present time. Progress has been made in every department of its work and further progress is assured for the ensuing year under these efficient and energetic managers.

Dr. Compton Riely (1897) was recently married to Miss Hughes of Lynchburg, Va., at the residence of Dr. Guy Steele, in Cambridge, Md. Dr. Riely has made rapid progress in his profession since his graduation and is one of the rising young surgeons of this city. The BULLETIN offers congratulations upon his recent good fortune in securing as a partner for life a most excellent and popular young lady.

DEATHS.

Dr. John W. Bayne, a graduate of the University of Maryland of the class of 1869, died at his residence in Washington, D. C., on May 17, after an acute illness. Dr. Bayne was born in Prince George's county, Maryland, 59 years ago. Soon after graduation he was appointed surgeon in the United States Army and assigned to duty at Fort Foote, near Washington. After resigning from the army he engaged in practice in Washington, and soon became one of the leading surgeons of that city. For some years he held the chair of professor of clinical surgery in the University of Georgetown, and was president of the medical board of Providence Hospital. During the Spanish-American War he was appointed major and brigade surgeon in the United States Army. He was a member of the Alumni Association of the University of Maryland in the District of Columbia, and was a most loyal friend of his old Alma Mater as he was one of her most gifted children.

Dr. Bayne was a most genial and lovable man, admired and respected by all who knew him for his manly and upright character and professional ability. He married soon after graduation Miss Mary Ashby, a daughter of Col. Robert S. Ashby of Fauquier county, Virginia, a lady distinguished for her beauty of person and character, who now survives him with a family of six children.

Dr. M. W. Donovan of the class of 1866 died recently after a long illness. Dr. Donovan represented the city in both branches of the City Council some years ago and also was at one time a member of the House of Representatives of Maryland. He was an influential politician and useful citizen and was highly respected for his honesty and upright character. He was never actively engaged in the practice of medicine.

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THE DIAGNOSIS AND TREATMENT OF TUBERCULOSIS OF THE KIDNEY.*

BY RANDOLPH WINSLOW, A.M., M.D.,

Professor of Surgery, University of Maryland.

The very courteous invitation to read a paper before this distinguished body reached me at a time when I was much occupied with my professional duties, and consequently unable to devote that thought and care to the preparation of a paper which the occasion demands. In considering, however, how I might occupy the time at my disposal in a profitable manner, the subject of tuberculosis of the kidney presented itself, and comes with an especial fitness at this time, since a case recently in my care was a native of this State. I will make this case the subject of my remarks today.

J. H., white, age 23 years, laborer, was admitted to the University Hospital, Baltimore, on February 16, 1905, and was discharged improved March 23. There is nothing of especial interest in his family or previous personal history. His health was good until the present ailment began. He denies having had venereal infection of any kind. About one year ago he experienced an increased frequency in micturition, with pain, and subsequently passed bloody urine. These conditions gradually abated, but about Christmas they reappeared with increased severity, and have continued to the present time. The patient is somewhat emaciated, and is cadaverous in appearance. He does not complain of any marked pain or discomfort in the region of either kidney, nor can the kidneys be palpated. He has not had symptoms of renal colic, and his distress is referred to the bladder. On examining the bladder with the sound some pain was felt by the patient, but no stone or other pathological condition was detected. On admission his hemoglobin was 70 per cent., red-blood cells 4,000,000, and leucocytes 12,400 to the cubic mm. The examination of the urine showed specific gravity 1018; color, light; reaction, acid; a distinct ring of albumen, no sugar, and an abundance of pus. His temperature was rather irregular, and ranged from normal to 101° F., and the pulse-rate from 80 to 100. The urine was also examined for tubercle bacilli with negative result. The heart and lungs appeared to be normal, nor was there any evidence of disease of the testicles, epididymes or other external genitalia, whilst the prostate may have been somewhat enlarged. A cystoscopic examination was made by Dr. Page Edmunds, and revealed an almost normal bladder, with some inflammation and ulceration about the left ureteral orifice. A catheter could only be introduced a short distance into the left ureter, when it met with an obstruction. The right ureter was not catheterized. The diagnoses of tubercular ureteritis and nephritis was made. Lumbar nephrectomy was performed in the usual manner. The kidney was separated from its connections with some difficulty and brought out of the wound. It was enlarged, mottled and lobulated, resembling a fœtal kidney. The ureter was dilated and much thickened, and was divided quite low down. When the kidney was incised a number of caseous foci containing pus were found, and miliary tubercules were also present. The pus cavities corresponded to the calyces of the organ. The patient did reasonably well, passed urine in sufficient quantities, had but little elevation of temperature, and was able to sit up in ten days. He gained flesh and appetite, and left for home in a much improved condition, but still suffering some from painful micturition.

Tuberculosis of the kidney occurs both as a primary and secondary process. It is said that 15 per cent. of cases of renal tuberculosis are primary, whilst 25 per cent. of tuberculous patients have some secondary infection of the kidney. This infection is usually conveyed by the blood current, less frequently by an extension of the disease from some contiguous structure, whilst in rare cases there may be an extension from the bladder upwards along the ureter. The disease

*Read before the North Carolina State Medical Society at Greensboro, N. C., May 25, 1905.

may occur at any age from infancy to senility, but is most frequent from 20 to 40 years of age, and is found more frequently in females than in males. Both organs are involved in a considerable proportion of cases. The object of this paper is especially to call attention to the fact that in some cases, I might say in most cases, of renal tuberculosis the symptoms are referable to the bladder rather than the kidney, and these patients, as the one whose protocol I have read, have their bladders washed out for long periods without any corresponding benefit. It is, therefore, important that the practitioners of medicine should be on the alert to recognize the true condition as early as possible, in order that effective surgical treatment may be applied. The symptoms of this affection are by no means uniform. In some cases there may be no symptoms at all until a very late period; in all cases some time must elapse before distinctive symptoms occur. The family history in some cases will show a decided tuberculous predisposition, as in a case operated on by me where the paternal grandfather and grandmother, father and mother and three brothers died of tuberculosis, thus showing an hereditary tendency to some manifestation of this disease, and giving the clue to a correct diagnosis. Sometimes the first symptom will be pain in the renal region, acute and laminating, radiating down the ureter or reflected to the shoulder or other parts, or dull and aching and more or less stationary. A tumor mass more or less resembling the kidney may be the first sign noticed, or there may be no palpable lump in the loins. As has already been stated, the first and sometimes only symptoms will be referred to the bladder. Dr. George Walker, from whose elaborate article (Volume XII, *Johns Hopkins Hospital Reports*) I have obtained the statistical information herein detailed, says: "So much am I impressed with the great frequency of this symptom that I hesitate to make a diagnosis of renal tuberculosis when it is absent." Frequent and painful micturition is then a prominent symptom in almost all cases of tuberculosis of the kidney. In some patients the discomfort is of a burning character rather than painful, as was the case with a young colored woman upon whom I operated. The urine may be increased in quantity as well as in frequency, and will soon show pathological changes. It becomes cloudy or discolored from the admixture of blood, pus, epithelium and caseous material. The specific gravity is usually lower than normal, and the reaction acid or neutral. The occurrence of pus in an acid urine is strongly suggestive of trouble of the upper urinary passages, and not the bladder. The pus may be small in amount or may form a large part of the excretion. Blood in varying quantities is found at times in almost every case, and should be carefully sought for. Albumen is usually present, dependent upon the amount of pus in the urine. Tube casts may or may not be found. Tubercle bacilli can usually be found in the sedimented urine, but are sometimes overlooked. Other organisms are also generally present. When possible there should always be a cystoscopic examination of the bladder, and sometimes the ureters may be bougied, but there is always danger that the healthy ureter may be infected in this manner; hence it is best not to catheterize the healthy ureter in most cases.

Constitutional symptoms are generally absent or not marked at first, but usually occur before long. There is especially more or less elevation of temperature, with remissions and sweats as in other tuberculous conditions, progressive and often rapid loss of flesh, sometimes vomiting, and, when both kidneys are diseased, diminished excretion of urine, and eventually uremia. As the infection is frequently a mixed one, a blood count will often show a marked leucocytosis, and is a valuable adjunct in making a diagnosis.

This paper deals especially with the discrimination of renal tuberculosis from cystitis or other disease of the bladder, but there are other pathological conditions of the kidney that more or less simulate tuberculosis. Renal calculus presents many of the same symptoms, but there is an absence of as marked constitutional phenomena. The vesical irritation is not so pronounced; the urine does not contain tubercle bacilli, unless there is an association of tuberculosis with lithiasis, and a skiagraph will generally show a stone. Neoplasms do not cause the pronounced symptoms of tuberculosis; there is no pus in the urine, bladder symptoms are not present, and the tumor mass is larger and grows more rapidly.

Pyonephrosis from infection with pyogenic organisms is a more acute process as a rule, is often due to extension from below, and presents a larger and more painful tumor, with rigidity of the overlying muscles, and greater tenderness on pressure.

Hydronephrosis is not likely to be mistaken for tuberculosis.

Having determined the nature of the affection and the side diseased, it is important to ascertain the presence and functional competence of the

opposite organ. This is best done by a cystoscopic examination, by means of which the urine may be seen to escape from the orifice of the ureter, and in appropriate cases the ureters may be catheterized and the urine from both ureters collected and examined. The injection of 1 c. c. of a 20 per cent. aqueous solution of methylene blue into the subcutaneous tissues is also a valuable test, as this agent is promptly eliminated by the normal kidneys and but slowly by diseased organs.

Tuberculosis of the kidney is a fatal affection, and no case is known where the patient has recovered from the disease, though in some cases the fatal result is long delayed. Dietetic, climatic and medicinal treatment has no special power to arrest or cure the malady, and surgery alone offers some hope of restoration to health and usefulness.

From the foregoing remarks it will be seen that the treatment of renal tuberculosis is surgical, and when the patient's condition is sufficiently good to withstand a serious operation, and the opposite kidney is healthy, nephrectomy ought to be performed. Even if the opposite kidney shows evidence of disease, nephrectomy may be permissible if the kidney is disorganized and is a focus from which tubercle bacilli are being discharged. The presence of tuberculous disease of the ureter and bladder does not contraindicate a nephrectomy, as it is a matter of observation that the disease of these parts may remain stationary or progress but slowly when the affected kidney has been removed. As in malignant diseases in general, early operation is indicated. As soon as unilateral tuberculosis of the kidney can be determined the time for removal of the organ has arrived. In some cases where the condition of the patient is not favorable, or where there is extensive suppuration, it may be proper to do nephrotomy, and perhaps subsequently remove the kidney. Two methods may be employed to reach the kidney—the lumbar or the abdominal. It is always preferable to use the former when the tumor is not too large, as it is retroperitoneal, gives better drainage and has a lower mortality.

The following cases of undoubted tuberculosis of the kidney have also been under my care rather recently:

Case 2. Mrs. Z., white, 40 years of age, native of Maryland, was admitted on October 30, 1903, and discharged December 10, improved. Her family history has already been mentioned as showing a marked tuberculous tendency. She has had measles, scarlet fever, pneumonia and typhoid fever without sequelae. More recently has suffered with quinsy and muscular rheumatism. She is married and has eight living children and two who are dead. The first thing she can remember in regard to the present ailment is that her urine became dark and offensive; some time subsequent to this she felt something slip in her right side, followed by much pain, which has continued more or less since. She has lost weight and strength.

Present condition: There is a large mass on the right side extending from the ribs to the pelvis, hard, irregular, tender on pressure, but not very painful. Heart and lungs appear healthy. Does not complain especially of her bladder. Hemoglobin 70 per cent.; white cells 6000 to c. mm. Urine cloudy, thick sediment, albumen present, no sugar, slightly alkaline, and a large quantity of pus, crystals of triple phosphate, mucus and epithelium.

No cystoscopic examination was made. In view of her history, the presence of a tumor mass in the right flank and the presence of pus in the urine, it was thought that a condition of renal tuberculosis was present, and an operation was decided on. In view of the large mass, an anterior incision through the right semilunar line was made into the peritoneal cavity. The cecum and ascending colon were firmly adherent to the mass in the side, and there were many enlarged glands in the mesocolon which were adherent to each other. The colon was separated with difficulty, during which enucleation the mesentery was extensively detached from the bowel. The mass in the side consisted of inflamed tissue, forming a capsule for a tuberculous kidney. This capsule was an inch thick. The kidney and capsule were removed, and a tuberculous lesion of the kidney was found at the lower pole which had penetrated the kidney and caused the extensive infiltration of the surrounding tissues. It was not possible to remove all the glandular masses under the colon without unduly prolonging the operation and increasing the gravity of the situation. Some pus was also found under the colon. The wound was drained, and no untoward complication occurred. I feared greatly gangrene of the colon from the extensive injury to the mesocolon. She went home on December 10, and I am informed by her physician that her health has been restored, and that no tumor masses can be felt in her abdomen. She weighs 175 pounds, and has recently borne a 10-pound baby.

Case 3. P. F., colored female, aged 23 years, admitted to University Hospital on December 14, 1903, and discharged, improved, on January 15,

1904. Married; has had two children, who died at an early period; cause of death unknown. Mother died at age of 41 years, of phthisis. The patient says: "I suffer with my bladder and pain in my stomach." Three years ago she began to complain of frequent micturition, with discomfort referred to the neck of the bladder, which was of a burning character more than a pain. Bloody urine was passed for several months, but subsequently ceased, and the urine is now generally cloudy in appearance. At first there was no pain in the loins, but now at times pain is experienced in the kidney region. She has lost weight from 140 to 110 pounds. On admission the temperature was somewhat irregular, varying from normal to 101° F.; pulse 90 to 120. There was a palpable mass in the right loin. The urine was cloudy, specific gravity 1020, had a large ring of albumen, no sugar, pus cells in abundance, a few red cells and no casts. No tubercle bacilli were found in the urine or sputum. Both ureters were catheterized by Professor Hundley. From the right side purulent urine was obtained; from the left normal secretion.

Hemoglobin 36 per cent. Patient's general condition not very good. Lumbar nephrectomy was done in the usual manner, and the patient made a satisfactory recovery. She continues well, and has gained flesh and strength.

REPORT OF THE OBSTETRICAL CLINIC OF THE UNIVERSITY OF MARYLAND.

By L. M. Allen, M.D.,

Associate Professor of Obstetrics.

The obstetrical clinic of the University of Maryland is in a healthy condition, as is demonstrated by a comparison of the above report with that of a few years back.

In the year 1898 there were in all 370 confinements, as contrasted with 612 last year. The contrast is still greater when we add to the latest number a great many who applied to the Hospital for admission, but were turned away on account of the lack of accommodation in the Maternité. During the last year as many as nine were turned away in one week.

Beside the greater number of cases that are offered to the student, the clinical advantages derived from these patients is relatively very much greater than it was at that time.

The work of the students in the Hospital consists, first of all, in attendance upon confinement cases under the direction of one of the resident physicians. When the labor begins two students are summoned to the Hospital and remain on duty until the case is over.

During that time they make vaginal examinations, are questioned about the practical points in the case, and sometimes are allowed to act in the capacity of a physician and take charge of the case.

Four ward classes a week are given the year through. The men report in groups of four, and are first taken to the examining-room, where they practice abdominal palpation and pelvimetry. Particular stress is laid upon these two subjects, impressing upon the students the great importance of cultivating both as much as possible.

They are then taken to the lying-in ward, where they are allowed to examine the puerperal patients, and are questioned about all matters pertaining to the puerperium.

They are next taken to the laboratory and shown normal and pathological placentae, urine, etc., as well as baby stools.

In the out-patient department two students are assigned to a case as soon as the patient registers at the Hospital. They are required to visit this patient and make a preliminary examination, measure the pelvis and examine the urine not only at that time, but at various times until the confinement occurs.

With each confinement they are accompanied by one of the resident physicians, who supervises the case in a general way and is present in case anything pathological might arise.

In all of the work, inside and out, a close observation of the student's knowledge and attention to his cases is recorded and marked in his final year, and this is undoubtedly a stimulus to better things.

Report of Lying-In Hospital, Beginning June 1, 1904, Ending June 1, 1905.

Inside Clinic.

No. of confinements	251
No. of full-term confinements	241
No. of premature confinements	5
No. of miscarriages	4
No. of abortions	1
No. of cases of eclampsia	5
No. of cases of placenta previa	5
No. of cases of hydramnios	3
No. of cases of prolapse of cord	5

No. of cases of pseudo-cyesis..... 2
No. of cases of toxemia of preg..... 11
No. of cases of albuminuria..... 30
No. of contracted pelves..... 42
No. of forceps deliveries (high)..... 6
No. of forceps deliveries (medium)..... 2
No. of forceps deliveries (low)..... 12
No. of versions (external)..... 1
No. of versions (internal)..... 7
No. of destructive operations..... 3
No. of symphyseotomies..... 1
No. of Caesarean sections..... 6
Artificial interruptions of pregnancy..... 7
Perineorrhaphies (primary)..... 57
Perineorrhaphies (secondary)..... 7
Cervical lacerations (deep)..... 4
Mastitis..... 1
Post-partum hemorrhage..... 6
Ante-partum (accidental)..... 1
Mild infections (sapraemia)..... 10
Severe infections (sapraemia)..... 3

Bacteria infecting in these cases were:

Two pure streptococcus.

One gonococcus.

In the sapraemias:

Six were negative, three staphylococcus, one gonococcus.

Tuberculosis complicating..... 2
Fibroid tumors complicating..... 4
Maternal mortality..... 4

Cause of Deaths:

One died in sixth week of puerperium of acute miliary tuberculosis.

Second, death from shock following an attempt at version in a contracted pelvis.

Third and fourth died of eclampsia.

Infants:

No. of still births..... 10
No. of premature births..... 5

Of these, three died.

Purulent ophthalmia..... 2
Catarrhal ophthalmia..... 1

OUTSIDE CLINIC.

No. of confinements..... 361
No. of full-term confinements..... 330
No. of premature confinements..... 9
No. of miscarriages..... 19
No. of abortions..... 3
No. of cases of eclampsia..... 2
No. of cases of placenta previa..... 1
No. of cases of hydramnios..... 2
No. of cases of prolapsed cord..... 4
No. of cases of pseudo-cyesis..... 4
No. of cases of toxemia..... 3
No. of cases of albuminuria..... 5
No. of contracted pelves..... 40
No. of forceps deliveries (high)..... 6
No. of forceps deliveries (medium)..... 3
No. of forceps deliveries (low)..... 3
No. of versions (internal)..... 4
No. of destructive operations..... 1
No. of cases of mastitis..... 1
No. of cases of post-partum hemorrhage..... 6
No. of mild infections (sapraemia)..... 24
No. of severe infections (sapraemia)..... 5

Of the severe, two were mixed streptococcus and staphylococcus, one staphylococcus and colon bacillus, one pure streptococcus, one streptococcus and colon bacillus.

Maternal mortality..... 3

One death due to shock following a "destructive operation."

Second due to eclampsia of a very severe type.

Third occurred six hours, post-partum, suddenly before aid could be summoned. Autopsy in this case did not reveal the cause of death.

Infants:

Premature births..... 9

Four of these died before the patient was discharged.

Still births..... 22

It has been observed that the proportion of contracted pelves was much higher in the Hospital patients than it was in the out-patient department, being 16.75 per cent. in the former, as compared with only 11 per cent. in the latter. This was due to a more careful examination of the patients, and not to any difference in the physical development. With an addition to the staff this will in a great measure be corrected.

A CASE OF RADICAL MASTOIDECTOMY PERFORMED UNDER UNUSUAL INDICATIONS.*

BY JOHN R. WINSLOW, B.A., M.D.,

Clinical Professor of Nose and Throat Diseases in the University of Maryland; Laryngologist to the University Hospital.

Mr. C. H., white, farmer, aged 32 years, was first brought to me by his family physician, Dr. C. R. Winterson, April 15, 1904, with the following history:

The patient had been under the treatment of several physicians during three or four years for

*Read before the Section on Ophthalmology and Otology of the Medical and Chirurgical Faculty of Maryland, May 26, 1905.

catarrh of the throat and purulent discharge from the right ear, which latter had, however, ceased for a year past. He was subject to frequent colds, and his voice was husky most of the time. Nervous temperament, general health, good; no syphilitic taint. A brother and sister had tuberculosis; parents living and healthy.

For about eighteen months previous to my examination the patient had been subject to "nervous attacks," occurring at first perhaps once a month, then once in two weeks, then weekly.

The attacks at first seemed purely hysterical, as evidenced by alternate laughing and crying, and sensations of general numbness; in fact, they resembled the antics of a drunken man so closely that the family physician made a careful investigation before excluding this possibility.

As they increased in frequency they also became severer, and mental confusion appeared. The patient would lose himself in his own house, would not know what room he was in, nor what he was doing.

Two weeks prior to my examination his physician had noticed pain on pressure upon the mastoid, also neuralgic pain over the right eye.

Examination showed deviated nasal septum to the left and general catarrh of nose, pharynx and larynx. There was no pus in the nose.

Left Ear—Drum dull and retracted; marked posterior fold; drum movable; Eustachian tube patent; whispered voice two and one-half feet.

Right Ear—Drum destroyed; ossicular remains bound down in cicatrix; slight gummy exudate in bottom of ear; no pus; nerve deafness.

Pressure over right mastoid antrum caused local pain and also supraorbital neuralgia over right eye.

Owing to the highly neurotic type of the patient and of the symptoms, and a suggestion of periodicity, I advised keeping the ear clean and a trial of anti-malarial and nervine medication, at the same time suggesting the probability of mastoiditis as the underlying cause.

On September 27, nearly five and one-half months later, the patient and his physician again appeared, with the additional history that five weeks previously the patient had had an attack which took the form of a muscular spasm, lasting about eight hours. He did not lose consciousness at this time.

Three weeks later (two weeks preceding the visit) the patient was seized with muscular spasm ("cramps"), and in two hours lapsed into unconsciousness, in which state he remained about twenty-four hours. The respiratory muscles took part in the spasm, and it required the combined efforts of two physicians, practicing artificial respiration, to keep him alive.

The doctor assured me that in his belief the patient could not survive a similar attack, and urged upon both of us the absolute necessity of doing something to prevent its recurrence.

Each of these attacks had followed a "cold" (infection). A most minute examination revealed an improvement, if any change, in the aural condition. The right ear was absolutely *dry,* and there was *no tenderness* on pressure over the right mastoid antrum.

The possibility of some disease of the central nervous system suggested itself to me, and a prominent neurologist was consulted, with no elucidation of the condition.

The patient was placed in the University Hospital for further investigation.

During a period of nine days the *temperature* was mostly normal, and on four mornings was subnormal (two 98° and two 97°). A general physical examination revealed a normal condition of all the organs. Ophthalmoscopy showed a normal eye-ground; there was no nystagmus. The ocular movements were normal, also the pupillary reaction.

In short, there was absolutely nothing in the whole body to account for the condition, except a non-suppurating and apparently cicatriced ear.

Two conditions suggested themselves as a possible cause—latent chronic brain abscess, and irritation or inflammation of the labyrinth.

Of the former, the only indication was an occasional drop of the temperature below normal. No headache, nausea, vomiting, nor chilly sensations were present. Fundus oculi normal. The long duration of the symptoms rendered it improbable.

As to the latter, the patient had spoken of occasional dizzy feelings; he had no outspoken vertigo, and could walk a crack, with eyes open or shut, as well as anyone; sudden movements of the head to the diseased side caused no giddy feelings; there was no facial paralysis; tinnitus was not prominent; nerve deafness was present.

With a frank admission of my ignorance of the exact condition, operation was offered and accepted as a means of diagnosis. This I undertook October 3, 1904, with the determination to open up the semi-circular canals or invade the brain, as indications might lead me. The Körner radical exenteration was selected.

The mastoid cortex was not abnormally dense; the cellular tissue exhibited a universal intense, venous engorgement (purple color). It was slightly softened, but no granulations were found anywhere except a few in the mastoid antrum. No pus and no cholesteatoma was present. The remnant of the malleus and the incus was removed and the tympanum curetted. The horizontal semi-circular canal was exposed, but exhibited no fistula nor other indication for interference.

Considering the venous engorgement a reasonable explanation of the cerebral and labyrinthine irritation, I deemed it unwise to expose the sigmoid sinus or the dura mater.

Knowing that the wound would have to be cared for by the family doctor, who was unfamiliar with aural manipulation, I did not close it, as I should have preferred, so that healing was considerably prolonged. Otherwise recovery was uneventful. The patient was discharged from the hospital in seventeen days (October 20), his temperature never having exceeded 100°.

April 4, 1905, the doctor reported the wound entirely healed, the meatus free from discharge, and that the patient *had had no return* of the "nervous attacks" (six months).

We well know that venous stasis and coaccumulation will cause irritation of the respiratory, convulsive and other nervous centers; also that inflammation of the environs of the fenestra ovalis and rotunda, attended by simple *irritation* of the labyrinth, causes similar symptoms to actual disease of this organ. Numerous cases are recorded of relief of such symptoms by ossiculectomy, alone and associated with the radical mastoid operation, or in diseased conditions of the labyrinth by partial or total operative destruction of this organ.

In conclusion I venture to predict that in the near future the operative invasion of the petrous bone and of the labyrinth for *diagnostic* and curative purposes will be made with the same justifiability and success in *non-suppurative* conditions of these regions as is now done for the detection and cure of suppuration and its complications.

Dr. R. B. Warfield, class of 1884, is Associate Professor of Anatomy in the Baltimore Medical College and an ex-Surgeon-General of Maryland. He ranks among the popular surgeons of the State. Being a gentleman of courtly and polished manners and of refined and cultivated tastes, he is one of the social leaders of the profession of the city.

ABSTRACTS AND EXTRACTS

THE BIOLOGY OF THE MICRO-ORGANISM OF THE ACTINOMYCOSIS.—The following are the "General Remarks and Conclusions" of Dr. J. Homer Wright's (1892) Gross Prize Essay elsewhere mentioned:

Branching filamentous micro-organisms have been isolated in pure culture from 13 cases of actinomycosis in man and from two cases in cattle. The micro-organisms seem to be all of one species, for the differences among the various strains are no greater than among various strains of tubercle or diphtheria bacilli.

The micro-organism grows well only in a jar and bouillon cultures, and in the incubator. In the other usual culture media and at room temperature it grows only very little or not at all. It is essentially an anaerobe. It does not form spore-like reproductive elements. In cultures its colonies are similar in character to colonies of the micro-organism in the lesions of actinomycosis. If colonies of the micro-organism are immersed in animal fluids, such as blood serum and serous pleuritic fluid, the filaments of the colonies in immediate contact with the fluid may, under certain unknown conditions, become invested with a layer of hyalin cosin-staining material of varying thickness, and the filament may then disappear. Thus structures are produced that seem to be identical with the characteristic "clubs" of actinomycosis colonies in the lesions.

Inoculation experiments on animals were made with the cultures of the micro-organism from 13 cases, including the two bovine cases. All of these strains were found to be capable of forming the characteristic "club"-bearing colonies in the tissues of the experimental animals. These colonies were either enclosed in small nodules of connective tissue or were contained in suppurative foci within nodular tumors made up of connective tissue in varying stages of development.

With the cultures from most of the cases nodular lesions identical in histological character with those of actinomycosis were produced in inoculated animals, and with some of the cultures relatively extensive lesions considering the size of the animal. The most extensive lesions showed little progressive tendency, and in only a very few instances did multiplication of the micro-organism in the body of the inoculated animal seem probable. In view of the negative or ambiguous results of those who have inoculated healthy animals with actinomycosis directly from lesions, it

would seem that the results of the inoculation of animals with the cultures described in this paper affords as much proof as can be expected from such experiments that the micro-organism in the cultures was identical with the micro-organism in the original lesions.

From my observations and from a study of the literature I am of the opinion that but one species of micro-organism is the characteristic infectious agent in typical actinomycosis, and that is one with the properties and characters herein described. This micro-organism should retain the generic and specific names of *Actinomyces bovis* given it by Bollinger and Harz. De Torie and Trevisan consider the generic name *Actinomyces* untenable, because the generic name *Actinomyce* was given by Meyers (1827) to a fungus described by him (*Actinomyces Horkelii*). Inasmuch as this generic term of Meyers has not received recognition as the tenable name of a genus in the literature of the fungi, the view held by De Torie and Trevisan seems to me to be based on an unreasonably strict interpretation of the principles of botanical nomenclature.

Between actinomyces from the human and bovine cases I have found no difference which seems to be sufficient to justify their classification as separate species.

I do not accept the prevalent belief, based on the work of Bostroern, Gasperini and others, that the specific infectious agent of actinomycosis is to be found among certain branching micro-organisms, widely disseminated in the outer world, which differ profoundly from actinomyces bovis in having spore-like reproductive elements. I think that these should be grouped together as a separate genus, with the name of *Nocardia,* and that those cases of undoubted infection by them should be called nocardiosis, and not actinomycosis. The term actinomycosis should be used only for those inflammatory processes the lesions of which contain the characteristic granules or "drusen." That a nocardia ever forms these characteristic structures in lesions produced by it in man or cattle has not been convincingly shown.

Because the micro-organism here described does not grow well on all the ordinary culture media, and practically not at all at room temperature, I do not believe that it has its usual habitat outside the body. It seems to me very probable that *Actinomyces bovis* is a normal inhabitant of the secretions of the buccal cavity and of the gastro-intestinal tract, both of man and animals, but I have no proof of this to offer at the present time. In these secretions it should not exist in the characteristic forms seen in the lesions, but it probably will be found in the form of fragmented filaments growing in company with bacteria and not now differentiated from them. I believe that the part played by foreign bodies so frequently found in actinomycotic lesions is not that of the carrier of the micro-organism into the tissues from without, but that the foreign body, by its traumatic and irritative effect, furnishes a nidus in the tissues for actinomyces which enters therein with the secretions from the buccal cavity and gastro-intestinal tract, develops into characteristic colonies, and produces lesions which we call actinomycosis.

Concerning the clubs of the actinomyces colony, I may state that I am unable to decide whether they are an essential product of the micro-organism itself, that is, a kind of product analogous to capsule formation among the bacteria, or a deposit upon the micro-organism from the surrounding tissue and fluids. According to my observations, animal fluids seem to be essential for their production.

The chief function of the clubs or of the hyaline envelope surrounding the peripheral filaments of a colony of actinomyces bovis is, I think, to protect the mass of the colony from the destructive action of the juices and cells of the tissue. It has been well shown by the work of Bostroern and others that the clubs are only formed when there is evidence of resistance on the part of the tissue toward the micro-organism. In rapidly-spreading cases or disseminated cases of actinomycosis when the resistance of the tissue to the infection is apparently very slight, little or no club formation may occur, and the colonies may consist only of masses of naked filaments.

Concerning the importance of the bacteria, which are so frequently found accompanying the specific micro-organism in the lesions, I can only say that in some cases I believe that they play an important part in the extension of the disease. There is no doubt, however, that some cases of actinomycosis are pure infections with *Actinomyces bovis,* and I am sure that it alone is capable of acting as the sole infectious agent.

The so-called spores, cocci and bacilli described by various writers in the granules or "drusen" of actinomycoces, directly from the lesions, are either products of degeneration and disintegration of the filaments of the specific micro-organism or are real micrococci and bacilli growing in symbiosis with it.

In consideration of the fact that *Actinomyces bovis* has never been shown to have a high degree of virulence for experimental animals, it seems desirable to offer some explanation of the progressive character of some of the spontaneous cases. In explanation it may be pointed out that in addition to the very important factor of individual susceptibility or lack of resistance to the infection, the factors of secondary bacterial infection and of continuous reinfection by way of sinuses connecting with the buccal cavity and with the gastro-intestinal canal may be of great importance. That such sinuses are common in actinomycosis is well known, and that repeated reinfections with this specific micro-organism, as well as others, could thus easily occur, is obvious if the assumption be true that *Actinomyces bovis* is a regular inhabitant of the buccal cavity and of the gastro-intestinal tract.—*Pub. Mass. Gen. Hosp.*, Vol. I, No. 1.

Etiology of Fissure in Ano.—Dr. J. Rawson Pennington (1887) of Chicago expresses the opinion (*Journal of the American Medical Association*) that the theories usually accepted as the cause are erroneous, and that a more comprehensive etiology is needed. He regards the location of the ulcer as anatomic and as depending principally on the support given to the tissues of the anal canal by the sphincter and levator ani muscles. When the canal is overdistended the dorsal surface receives the least support from these muscles, the anterior the next, while the sides receive the greatest. At the terminal portion this relative support is due to the difference in the distance between the posterior commissure and the tip of the coccyx, the origin of the external sphincter and the tendinous center of the perineum, its insertion and the anterior commissure. The posterior fibers of the muscle are more deployed than the anterior; hence when pressure is made from within outward it is obvious that the weakest point in this muscle is at or near the posterior commissure; the next weakest point at or near the anterior commissure. Therefore when this canal is placed under sufficient stress to rupture its tissues, the tear, all things being equal, should occur first on the dorsal surface, as it receives the least muscular support: second, on the anterior surface, as it is the next weakest point, and, lastly, on the sides.

Dr. C. Urban Smith, class of 1889, is Professor of the Principles and Practice of Medicine and Diseases of the Stomach in the Maryland Medical College. He is also an ex-President of the Baltimore Medical and Surgical Association and an active worker in other medical societies. Dr. Smith has made rapid progress since graduation as a clinician, and is forging to the front among the practitioners of the city.

Dr. Harry Lee Smith, class of 1894, is Professor of Diseases of Children and Lecturer on Bacteriology in the Woman's Medical College of Baltimore. Dr. Smith is one of the most promising of the younger members of the profession in the city, and has social and intellectual qualifications which should guarantee him a distinguished future.

DEATHS.

Dr. Thomas B. Steele, class of 1844, died at his residence in Cambridge, Md., on June 22, in the eighty-fourth year of his age. He was descended from a distinguished father, and bore throughout life the noblest traits of his ancestors. He was born in Cambridge, Md., in 1822, and graduated from the University of Maryland in 1844. In 1846 he was appointed an assistant surgeon in the United States Navy, and served during the Mexican War. In 1850 he was ordered to the China station, and accompanied the fleet under Commander Perry to Japan in 1853, and again in 1854 when the first Japanese treaty was secured and ratified. He distinguished himself in the yellow-fever epidemic that ravished Norfolk and Portsmouth in 1857, and was presented a gold medal by the citizens of those communities in recognition of his services. Being a Southern sympathizer, he resigned from the Navy in 1861 and returned to his old home in Cambridge, where he soon acquired an extensive practice, from which he retired only a few years ago.

Dr. Steele married Miss Isabella Henry, who survives him with two sons and one daughter. Dr. Guy Steele, class of 1897, is one of his sons and his successor in practice. Dr. Steele was connected with many of the most prominent families in the State, and was one of the most distinguished physicians on the Eastern Shore. He was a gentleman of the highest character and attainments, and leaves to his family a record of which they are most justly proud.

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EDITORIAL

TO THE FRIENDS OF THE BULLETIN.—Whilst the promoters of the BULLETIN feel encouraged over the success of the publication and pleased with the words of commendation which have come from numerous friends, they are not satisfied with present results from a number of standpoints. It must be borne in mind that the main purpose of the publication is to stimulate literary work among the alumni of the University by encouraging men to write original papers, to report instructive cases, or to contribute articles of interest to the alumni from a personal standpoint. It is intended that much of this work shall be done by members of the Hospital and teaching staff, but it is also desired that the alumni, wherever located, will make use of the pages of the BULLETIN and become its supporters. The editors of the BULLETIN have made abstracts of articles published by the alumni in other journals, which have appeared in previous issues, but it is manifestly impossible for them to follow all of these papers as they appear, and the request is now made to our alumni to prepare abstracts of their work as published in other publications and to forward them to us for use in the BULLETIN.

A second purpose of the BULLETIN is to introduce the alumni of the University to their fellow-alumni through the personal notices which appear in each issue. It is our aim to hunt up the record of every alumnus, and whenever possible to say something pleasant about him. We all are presumed to be human and to have points in common. It must be pleasing to old classmates to hear of former associates through a medium such as we offer. Men who are intimate or in daily association at college, after graduation scatter over wide sections of country, and many are never heard from. Why should these associations of youth disappear? Can we not keep in touch with our old friends and rejoice in their advancement in life? Have we no interest in our old classmates after the doors of college life have closed against us? Each one must answer these questions for himself, for upon his own answer will depend very largely the results which come to him personally. The BULLETIN will exist for all of our alumni, but it will be impossible for its publishers to send it monthly to each alumnus unless a regular subscriber. As much as we would like to do this, it is not a wise policy to do so. The man who subscribes for the BULLETIN will read it and will appreciate its contents. He will do more to advance its interests and he will receive value for value given. With the wider growth of the BULLETIN, with increased prosperity, the greater will be its value to all of its readers. It was not established as a money-getting enterprise; its mission is a larger one than a commercial venture, but at the same time its success financially must determine the extent of its usefulness to its readers. We have no hesitation, therefore, in asking the alumni of the University to aid us in every way in our efforts to serve them and to advance the interests of the old mother that nourished them and gave them entrance into the profession of medicine. In many ways the old mother can serve her children if they keep in touch with her. Let not the busy world and the selfish interests of life win us away from sentiments and ties which should bind us to the old institution and to the old associates of University life. In the past the alumni of the University have been allowed to stray from all communication with their Alma Mater to too great an extent. It is now the purpose of the BULLETIN to correct this policy and to keep in touch with every man who holds the University degree. We may have some difficulty in reaching every alumnus, but the search will be made, and if we fail to find him in the months to come it will be no fault of ours.

DISTINGUISHED ALUMNI OF THE UNIVERSITY OF MARYLAND.—The BULLETIN publishes in the present issue a brief sketch of the living alumni of the Medical Department of the University of Maryland who are engaged in teaching in other schools throughout this country. The list is as complete as it can be made at this time, the BULLETIN promising to make additions or corrections as they come to light. It is believed that this record of the distinguished alumni will prove not

only interesting, but a matter of pride to all of the graduates of the old University. The record is one which the friends of the University need not feel ashamed of and one which the present Faculty can boast of, because it is largely the work of those who had charge of the affairs of the University in the past forty to fifty years and before many of the present members of the Faculty had graduated. The history of the University can be read in the character of the men who have gone out into the busy world and made places for themselves in other institutions. Here in Baltimore many of the alumni fill chairs in other medical schools which they have in great measure organized and developed into successful educational institutions, coming into honorable competition with the older University, and by their youthful vigor stimulating their Alma Mater to renewed activity and progressive lines of policy. If there has ever been any feeling of sensitiveness on the part of the Faculty of the University towards the younger institutions that have come into the educational field of work in this city, we believe this feeling has long since died out. Certainly, we can claim at this time that the relations between the medical schools of Baltimore are fair and friendly, and that each one recognizes the right of the other to exist. If a rivalry exists, it is a legitimate one and based upon the desire of each school to improve its facilities and to offer the best it can give to its students. Baltimore offers unexceptionable advantages as a center of education for medical students. Her central position on the Chesapeake, with her large foreign and negro population affording the greatest abundance of clinical material, mild and temperate climate and cheapness of living, all combine to offer the medical student advantages not found of the same value elsewhere. With these natural conditions so favorable, there is no reason why every medical school in this city should not have every seat and laboratory filled with students drawn from every part of the civilized world. There is no occasion for a contest for students among our schools—the only rivalry that should exist is one based on the policy of improvement of the educational plant, upon efficiency of service and the avowed purpose to uphold the very highest standards of instruction and of requirement for graduation. Every medical school should aim to widen Baltimore's reputation as a center of education by establishing here the highest standards and a reputation for the very best quality of instruction. We believe that this principle is at work in the majority, if not all, of the medical schools of our city. No one can look back over the past thirty years and contrast present with former methods without being impressed with the splendid strides made during these years. When it is remembered, too, that many of the men now engaged in teaching were educated under the old systems of instruction, it is easy to see how men adapt themselves to new conditions and new requirements. The BULLETIN claims a bright future for the older University, and believes that her younger sisters, and may we not say daughters, have equal opportunities for advancement.

VACCINATION AFTER ONSET OF SMALLPOX.—That vaccination can be successfully performed after the onset of smallpox no longer admits of doubt. Dr. J. Cooke Hibberd (*Lancet*, May 20, 1905) succeeded in eleven instances out of twenty after the appearance of the eruption, typical vesicles being obtained in seven of these from vaccination done as late as the fourth day. Dr. F. Robinson, in the same journal of June 10, corroborates this result, succeeding in eight of twenty-two cases. The operation was performed by him from the first day of symptoms to the first day of vesicular eruption, inclusive. It is interesting to note that but four of the above were secondary vaccinations. As to modifying influence on symptoms and courses, it seems more than doubtful in view of the severity of several of the cases. For instance, four of the last series were confluent and one died. These observations are of value in view of the tendency to regard such results as a point in differential diagnosis against smallpox. In this connection we may recall the fact that the late Dr. Richard S. Steuart of Baltimore claimed to have used vaccination after the onset of symptoms of variola with highly favorable results, and mention of the subject by others may be found from time to time in the literature.

DR. J. HOMER WRIGHT'S PRIZE ESSAY.—The work done by Dr. Wright (1892), who is director of the Clinico-Pathological Laboratory of the Massachusetts General Hospital in Boston, is described at length elsewhere. It is a valuable contribution upon a subject in which there has hitherto been much confusion. He concludes that there is but one causative micro-organism—the *actinomyces bovis*—and this is identical in men and cattle. He thinks that this organism may be a normal inhabitant of the mouth and intestinal tract. Dr. Wright's exhaustive research forms the first number of the publications of the Massa-

chusetts General Hospital. It is copiously illustrated by micro-photographs, and should be read by all his fellow-alumni. We are well represented in Boston and Harvard University by two such distinguished alumni as Councilman and Wright.

Medicine of the Future. — We hear much about the physician of the future. He is to be an officer of health, and his functions are to be the preservation of health. Disease is to be relegated to the rear; it is to become an old fogy—a back number, and our successors are to deal with the well rather than with the sick. One might almost be induced to believe that the practitioner of medicine and the specialist would no longer have a place in that blessed time to come. That the relative importance of prevention, of pure food, of domestic and public hygiene, etc., will be vastly greater as the world grows older and wiser we may freely allow. But that any golden age is impending within any reasonable period, when there will be such perfect accord, such enlightened observance of all the dictates of reason and prudence, as to banish disease from the earth or preclude the need of the physician for the care of the sick, is fanciful and absurd.

It can be safely said that the study and investigation of methods of cure and of the old-time pursuit in which our profession has been always engaged will remain for us to do a legitimate employment and worthy in every way of the highest praise and encouragement. Methods will change and improve, and light will be thrown into the dark places, but human nature will remain the same—the prey of sin, of suffering, of sickness, and these will ever require something more than the mere officer of health.

SHORT SKETCHES OF DISTINGUISHED ALUMNI OF THE UNIVERSITY OF MARYLAND.

The Bulletin proposes to publish from time to time the record of every alumnus of the University of Maryland who has distinguished himself in his professional career, or who has established a position for himself in the practice of his profession, or as a citizen in the community in which he lives. It is believed that this record will be read with interest by the alumni who receive the monthly visits of the Bulletin, and that it will stimulate a pride in all who cherish kindly feelings towards their old Alma Mater. If the alumni are not specially interested in the advancement and prosperity of their old classmates, the Faculty of the University of Maryland is proud of the record any graduate may make, and rejoices in whatever good fortune may come to him after he has left the walls of the old University. In publishing these records the Bulletin will first take up in alphabetical order the alumni who hold chairs in educational institutions other than the University of Maryland.

Dr. Alexander C. Abbott, class of 1884, is Professor of Hygiene and Bacteriology and Director of Laboratory of Hygiene in the University of Pennsylvania; Chief of the Bureau and President of the Board of Health of the city of Philadelphia. Dr. Abbott has a well-established reputation as a scientist, teacher and author. His scientific work and his textbooks have made him a worldwide renown.

Dr. Henry J. Berkley, class of 1881, is Clinical Professor of Psychiatry in the Johns Hopkins University, and is widely known for his original investigations and as an author in his special line of work.

Dr. Charles F. Bevan, class of 1871, has for a number of years filled the Chair of Surgery in the College of Physicians and Surgeons of this city, and has a distinguished record as a surgeon and teacher. Dr. Bevan has recently been elected to the position as Dean of his College, and he brings to this duty a superior business ability and large experience in educational methods. The College will make progress under his administration.

Dr. H. H. Biedler, class of 1876, is Professor of the Principles and Practice of Surgery and of Clinical Surgery in the Baltimore University School of Medicine, and also Dean of the Faculty. Dr. Biedler enjoys a large surgical practice in this and adjoining States, and has met with the success that comes to an energetic and forceful character. Though connected with another institution of learning, Dr. Biedler has always been a loyal friend of his Alma Mater and always active in the work of the Alumni Association. Coming to Baltimore as an entire stranger, after several years of practice in Virginia, he has forged a position for himself by his determination and industry.

Dr. B. Bernard Browne, class of 1867, is Professor of Gynecology in the Woman's Medical College of Baltimore and a widely-known special-

ist in diseases of women. He is a Fellow of the American Gynecological Society and the author of a number of valuable papers on gynecological subjects. He has been prominently identified with the medical and social life of Baltimore since his graduation in medicine.

Dr. James Bordley, class of 1896, is Clinical Professor of Diseases of the Eye and Ear in the Woman's Medical College of Baltimore. Dr. Bordley is one of the rising young oculists of this city, and has a distinguished career ahead of him.

Dr. Wilmer Brinton, class of 1876, was for a number of years Professor of Obstetrics in the Baltimore Medical College, but retired a few years ago from the active work of teaching, and is now Emeritus Professor. Dr. Brinton was a most popular teacher, as he has been for years a most successful and popular practitioner. He has led a most active and useful life as teacher, practitioner and public-spirited citizen, at all times progressive and aggressive in support of the highest interests of his profession. He has been at all times loyal to the old Alma Mater.

Dr. James Carroll, class of 1891, is Associate Professor of Bacteriology and Pathology in the Medical Department of the Columbian University, Washington, D. C. Dr. Carroll has reached a high position of distinction in his special line of work, and has a brilliant future ahead of him as teacher and scientific investigator.

Dr. G. Wythe Cook, class of 1869, is Professor of Clinical Medicine in the Medical Department of Columbian University, Washington, D. C. Dr. Cook is a most popular and successful practitioner, and is widely known as an author and teacher. He is an ex-President of the Alumni Association of the University of Maryland in the District of Columbia.

Dr. Theodore Cooke, Jr., class of 1891, is Professor of Eye and Ear Diseases in the Baltimore University. He is among the prominent young specialists who are adding to the reputation of Baltimore as a medical center.

Dr. W. T. Councilman, class of 1878, is Shattuck Professor of Pathology and Anatomy, Harvard University, Cambridge, Mass. After graduation Dr. Councilman took a post-graduate course in Europe, and subsequently became Associate Professor of Anatomy and then of Pathology in the Johns Hopkins University. He now enjoys an international reputation as a teacher and scientist.

Dr. S. Griffith Davis, class of 1893, is Professor of Surgery in the Woman's Medical College of Baltimore and acting Dean of the College. Dr. Davis holds a number of positions as surgeon to railroad and industrial corporations, and is making a place for himself among the distinguished surgeons of this city.

Dr. Samuel T. Earle, class of 1870, is Professor of Physiology and Diseases of the Rectum in the Baltimore Medical College. Dr. Earle began the practice of medicine in Centreville, Md., but removed to Baltimore some twenty years ago and took up the specialty of rectal diseases. He has since risen to national prominence in this line of work, and is a distinguished authority in his branch of surgery. Dr. Earle has been most active in the work of reorganization of the Medical and Chirurgical Faculty of Maryland, and at the last meeting was honored with the presidency. He is a most useful man and a high-toned, courageous and polished gentleman.

Dr. Henry D. Fry, class of 1876, is Emeritus Professor of Obstetrics and Clinical Professor of Gynecology in the University of Georgetown, Washington, D. C. He is a fellow of the American Gynecological Society and a distinguished authority and able practitioner of obstetrics and gynecology. Dr. Fry is an ex-President of the Alumni Association of the University of Maryland and a warm friend of the University.

Dr. J. William Funck, class of 1888, is Professor of Eye and Ear Diseases in the Maryland Medical College and a well-known specialist. Dr. Funck was at one time Dean of this College and contributed largely to its growth as an educational institution. He and his associates in the Faculty have been untiring in their efforts to increase Baltimore's reputation as a center of medical education by founding and developing a modern and wide-awake medical school. The continuation of such energy and enterprise as have been manifested up to this time will result in a permanent success for the Maryland Medical College.

Dr. Harry Gross, class of 1896, is Professor of Operative and Clinical Surgery in the Maryland

Medical College. Dr. Gross after graduation was trained in the anatomical department of the University of Maryland and soon became an accomplished anatomist. He has since risen rapidly into prominence as a surgeon, and has before him a career of wide usefulness and success.

Dr. W. T. Howard, Jr., class of 1889, is Professor of Pathology in the Western Reserve University, Cleveland, Ohio. Dr. Howard has already reached a position of high distinction in his line of work, and bright prospects seem ahead of him, as he is still comparatively a young man.

Dr. Thomas S. Latimer, class of 1861, is Professor of the Principles and Practice of Medicine in the College of Physicians and Surgeons of Baltimore. Dr. Latimer is one of the best known and most highly respected physicians in this State. He has for years been prominent and active in the making of medical history in Maryland, and has contributed ably to the advancement of his profession and to the dignity and nobility of its standing. He is a gentleman of refinement, culture and highest character, and belongs to that class of physicians who have made the profession a blessing to humanity.

Dr. W. Milton Lewis, class of 1888, is Professor of Normal Histology and Clinical Microscopy in the Woman's Medical College of Baltimore. Dr. Lewis has done most creditable work since graduation, and the future promises well for him.

Dr. Alexander D. McConachie, class of 1890, is Associate Professor of Materia Medica in the Maryland Medical College; Surgeon to the Eye and Ear Department of the Northeast Dispensary, and consulting oculist to the Church Home Infirmary. Dr. McConachie is well known as a specialist in eye and ear diseases, and with his energy and force of character has a useful future before him. He is a loyal alumnus of the University, and is active in promoting the interests of the Alumni Association, of which he is a most useful member.

Dr. Tilghman B. Marden, class of 1892, is Associate Professor of Biology and Histology in the Baltimore Medical College. Dr. Marden has done most excellent work in the laboratory, and is the author of a textbook on the subjects in which he is engaged in teaching, which is deservedly popular with medical students. He is an unassuming, earnest worker, and much good work may be expected of him.

Dr. Samuel K. Merrick, class of 1872, is Professor of Diseases of the Throat and Nose in the Baltimore Medical College, with which school he has been associated for over twenty years and to the growth of which he has so ably contributed. He has reached a position of high distinction in his line of work, and has a very extensive practice. For many years he has been actively identified with the social and medical history of Baltimore, enjoying the respect and confidence of all who know his genuine worth and upright character. He is a genial, cultivated gentleman and loyal friend, one who can be relied on and trusted when the true man is most needed.

Dr. T. Morris Murray, class of 1873, is Professor of Physical Diagnosis, Laryngology and Rhinology in the University of Georgetown, Washington, D. C. Dr. Murray is one of the most distinguished specialists of Washington. He is a most polished and accomplished gentleman, highly popular in the social life of the capital as well as with his professional associates. Dr. Murray's old classmates will recall this most genial associate of bygone days with great pleasure and rejoice in the good fortune which has come to him since graduation.

Dr. Charles O'Donovan, Jr., class of 1881, is Professor of Diseases of Children in the Baltimore Medical College. Dr. O'Donovan is the third of his name and family who has practiced his profession with distinction in this city. Grandfather, father and son have held the confidence of the public to a degree not excelled by that of any other family of medical men in the State. They have all been men of integrity, force and ability, and all graduates of the University of Maryland—the grandfather, John H., class of 1824; father, Charles, class of 1853, and son, Charles, Jr., class of 1881. With this family record the University of Maryland is justly proud of the present representative of the O'Donovan family, who has shown himself to be a worthy descendant of two of her distinguished alumni.

Dr. Cameron Piggott, class of 1882, has been Professor of Chemistry in the University of the South, at Sewanee, Tenn., since 1887, and is also Dean of the Faculty. Dr. Piggott has never practiced medicine, but has devoted his time to educational work, in which he has achieved distinction.

Dr. William H. Pearce, class of 1891, is Professor of Materia Medica, Therapeutics and Clinical Medicine in the Maryland Medical College. Dr. Pearce has rapidly risen into notice as a teacher and public orator, and will be much in evidence in the professional life of this city in the future. He has talents which only await upon opportunity for useful and successful exercise. He is an alumnus of whom the University expects a good deal in the years to come.

(To be Continued.)

NOTES AND ITEMS

Dr. E. B. Quillen, class of 1904, Resident Pathologist to the University Hospital during the past year, has resigned his position to accept an appointment as assistant surgeon in charge of the Atlantic Coast Line Railroad Hospital at Rocky Mount, N. C. Dr. Quillen has been a most popular and useful member of the Hospital Staff, and deep regrets are felt over his resignation. The new position offers him a higher promotion and a promising future.

Dr. W. B. S. Levy, class of 1904, has been elected Resident Pathologist to the University Hospital to succeed Dr. Quillen.

Dr. James S. Billingslea, class of 1905, was recently married to Miss Katherine Bell of this city.

Dr. W. N. Gassoway, class of 1904, Assistant Resident Physician to the University Hospital during greater part of last year, was recently married to Miss Emma Brown of Ellicott City, Md., a former nurse in the Hospital and a most attractive young lady.

Dr. H. C. McSherry, class of 1872, has recently returned to Baltimore after a residence of two and one-half years in Europe. Dr. McSherry was a well-known specialist in throat and nose diseases, and was prominent in medical and social circles in this city before his retirement from professional work. He is a most genial and sociable gentleman, and his old friends will gladly welcome him back to his old home.

The BULLETIN receives in exchange the *Georgia Practician*, a monthly medical journal published in Savannah, Ga., with Dr. John S. Howkins, class of 1897, as business editor. The BULLETIN congratulates Dr. Howkins on the substantial and prosperous appearance of his journal, and wishes him success in his editorial and journalistic career.

At the recent commencement of St. John's College at Annapolis, Md., the honorary degree of LL.D. was conferred upon Dr. J. C. Hemmeter of the Faculty of the University of Maryland. Dr. Hemmeter graduated in medicine at the University of Maryland, class of 1884. He subsequently took the Ph.D. degree at the Johns Hopkins University and spent several years in Europe in post-graduate work. He has made an international reputation as an author, teacher and scientist, and now in the prime of life gives promise of adding many valuable contributions to clinical and literary medicine.

Dr. F. J. Kirby, class of 1898, Visiting Surgeon to St. Joseph's Hospital, Baltimore, was married on June 27 to Miss Teresa J. Wertz of Washington, D. C.

Dr. J. P. McGuire, class of 1905, has recently located at Clarksburg, W. Va.

Dr. Ashby C. Byers, class of 1901, is practicing his profession at Lacey Springs, Rockingham county, Virginia, with much success.

Dr. Merton S. Pearre, class of 1900, is located at Harney, Carroll county, Maryland, and has built up a large practice. He has been a recent visitor to the University Hospital.

Dr. J. L. Berthold (1886) is practicing his profession with great success in Perham, Minn. He is already prominently identified with professional interests in his State.

Dr. W. D. Scott (1904) has recently located at Curtis Bay, Md., where most excellent opportunities are presented for professional advancement.

Drs. Jesse C. Coggins and Cornelius De Wesse have recently opened a sanitarium at Laurel, Md., for the treatment of nervous and mental diseases, alcoholic and drug addictions. These gentlemen have had training for this line of work in connection with the Maryland Hospital for the Insane at Catonsville, Md., and the Government Hospital for the Insane at Washington, D. C. Their sanitarium has every modern convenience for the care and treatment of patients. The location is very accessible and well adapted for this class of work.

The first number of the *Nurses' Annual* has just been issued by the students connected with the Training School for Nurses of the University Hospital. The *Annual* is most beautifully gotten up, and does great credit to its editorial committee and also to the Training School. We hope to see this publication continued from year to year by succeeding classes. The Training School now numbers over fifty pupil nurses, and will compare favorably with any school in this country.

Dr. E. T. Owens (1904), recently an assistant resident physician to the University Hospital, has located temporarily at his old home in Anne Arundel county, Maryland. Dr. Owens has political aspirations, and we would not be surprised to hear of his advancement in the field of politics within a short time.

Dr. N. E. Sartorius (1904) is located on Tangier Island, Virginia, and has already secured the entire practice of the Island, as he is the only physician there. He will have abundant opportunities to develop his self-reliance and resourcefulness, as there are no physicians within twenty miles' reach. The Island has a population of between 1000 and 1500 people. The only industry is oystering, fishing and crabbing.

Dr. J. McD. Josey (1904), who has spent the past six months in post-graduate work at the University of Maryland, has recently returned to his home in Lamar, S. C. Dr. Josey expects to locate and practice his profession in Sumter, S. C.

Dr. George Walker (1888) has been made Associate in Surgery in the Johns Hopkins Medical School.

Dr. Henry M. Thomas (1885) has been elected Vice-President of the American Neurological Association.

The following physicians have been recent visitors to the University Hospital:

G. W. Todd (1885), Salisbury, Md.
J. J. Woodward, Havre de Grace, Md.
R. G. Rozier, Lumberton, N. C.
A. B. Cannon, Sarasota, Fla.
J. W. Hebb, Jr., Glenelg, Md.
C. R. Drewry, Centralia, Va.
L. G. Owings (1900), Ellicott City, Md.
E. Hansen (1904), New York city, N. Y.
M. S. Pearre (1900), Harney, Md.
Joel Whitaker (1900), Raleigh, N. C.
W. F. Twigg (1883), Cumberland, Md.
H. E. Clemsen (1894), Port Deposit, Md.
C. W. Heffenger, Sykesville, Md.
G. J. E. Sponseller, Martinsburg, W. Va.

Prof. Randolph Winslow of the University of Maryland is now in attendance upon the meeting of the American Medical Association, held in Portland, Ore. After the adjournment of the Association meeting Professor Winslow will take a much-needed rest in visiting various points of interest in the West. The BULLETIN wishes him a most enjoyable visit and safe return. No man connected with the University works harder than the Professor of Surgery, and his many friends will rejoice in whatever pleasure may come to him during his absence from home.

The following changes and promotions have been made in the Faculty of the Medical Department of the University of Maryland for the ensuing year:

Dr. Daniel Base, Ph.D., has been elected Professor of Analytical Chemistry.

Dr. Arthur M. Shipley has been made Associate Professor of Surgery.

Dr. S. B. Bond, Clinical Professor of Genito-Urinary Diseases.

Dr. J. M. Craighill, Dr. J. E. Gichner and Dr. A. D. Atkinson have been made Clinical Professors of Medicine.

Dr. Gordon Wilson has been made Associate Professor of Clinical Medicine.

Dr. Hubert Richardson has been made Clinical Lecturer on Neurology and Psychiatry and Lecturer on Physiological Chemistry.

Dr. R. H. Johnston has been made Lecturer on Diseases of Throat and Nose.

Dr. Page Edmunds has been made Instructor in Genito-Urinary Diseases.

Dr. I. J. Spear has been made Instructor in Psychiatry.

Dr. Lewis W. Armstrong (1900), formerly of this city, is now practicing his profession with success in Breckenridge, Minn. Dr. Armstrong, with wife and child, has made a recent visit to his friends in this city. He gives a most encouraging account of his professional success, and has a most promising future ahead of him in the prosperous State of Minnesota. He has already secured a connection with one of the leading hospitals of his State, and is active in medical-society work of his county.

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NEPHRECTOMY FOR RENAL TUBERCULOSIS, WITH A BRIEF REPORT OF THIRTEEN CASES OF NEPHRECTOMY; MORTALITY FOLLOWING OPERATIONS NIL.

BY FRANK MARTIN, M.D.,

Clinical Professor of Surgery, University of Maryland.

In the following paper I wish to give a brief record of the nephrectomies that I have done for various causes, which embrace principally cystic kidneys, painful kidneys, ruptured kidney, from traumatism, hydronephrosis, movable kidneys that have not been relieved by fixation, and for malignant tumors of the kidney, both carcinomatous and sarcomatous, and one very interesting case of endothelioma of the adrenal gland.

One case in this list was done for the relief of a ureteral fistula, which was brought about by the operator who had the case under care prior to my seeing her, and accidentally cut the ureter in removing a pelvic mass.

What I wish principally to bring out is the advantage of early nephrectomy for the relief of renal tuberculosis, and in my list of nephrectomies there are three nephrectomies for renal tuberculosis.

I thought, in looking over these cases, that it might be of interest to take up some of the important points regarding renal tuberculosis and the chief indications manifestly justifying and calling for nephrectomy.

There is such a wide diversity of opinion among surgeons and pathologists regarding the entire subject that it is to me one worthy of study and consideration, and yet I offer this paper with much hesitation, because I can contribute so little and nothing that is new except my own personal experience in a few cases. My experience has convinced me, however, that cases of kidney tuberculosis are not always bilateral complications secondary to other foci of tuberculosis, which is maintained by some observers, but that occasionally, and not infrequently, are primarily renal and unilateral, and that in such cases its clinical course is widely different from that usually ascribed to it. I mean by this that tuberculous lesions are met with clinically in the kidney and other parts of the uro-genital tract without tuberculosis lesions being found in any other portion of the organism.

By properly applying the methods of investigation at our disposal, namely, bacteriological examination of the urine, catheterization of the ureters, as taught by Gustav Simon (who, according to Senn, "deserves the credit of having laid the foundation for more accurate means of diagnosis in the study and differentiation of renal affections, and should be regarded as the founder of rational renal surgery. He is also credited with having performed in 1869 the first intentional, well-planned nephrectomy"), the employment of the cystoscope, inoculation experiments upon animals, and careful renal palpation, etc., will oftentimes enable us to make a positive diagnosis in most of the cases during the early stages of the disease when surgical treatment is to be instituted. Differential diagnosis before these methods were taught were extremely seldom made, and very inaccurate and unsatisfactory.

Etiology.—We now know that the etiology and pathology of tuberculosis of the kidney are fairly well understood, and, like tuberculous disease in any other organ, may run an acute or chronic course, and we, therefore, have classified two forms—first, miliary tuberculosis, and second, chronic renal tuberculosis. (Caseous nephritis or nephro-phthisis, which is often complicated by some form of pus infection, gives us often a mixed infection to deal with.)

The former, namely, miliary tuberculosis, is a general infection, and, therefore, both organs are simultaneously affected, being almost invariably secondary to tuberculosis in other parts of the body. Whether it is primary or secondary, it is thought to be, without exception, associated with deposits elsewhere; is more common than chronic tuberculosis; more frequently found in childhood, whereas the chronic form is more often found

from adult life on, as it is always bilateral and accompanied with other grave forms of general tuberculosis. It is a hopeless and destructive affection, and surgical interference is not to be thought of, and, therefore, not to be considered in this paper.

It is the chronic or caseous form that is of interest to the surgeon, as it is often limited to one organ, and therefore admits of surgical interference. According to Rovsing, he found the disease unilateral in 216 cases out of 350, and more common in the right than in the left kidney.

Modes of Infection. — The infection occurs either through the blood, with or without tuberculosis in any other organ, or by an ascending infection from a tubercular process from the lower urinary tract along the ureter. This latter mode, however, is thought to be extremely uncommon. In this form the infection occurs in the substance of the kidney, and from one or numerous foci the disease involves the surrounding tissues until the entire organ is destroyed and converted into a large tubercular abscess.

One of the chief subjects of interest, I think, is as to the relative frequency of renal tuberculosis as a primary disease, and the relation renal tuberculosis bears as a secondary infection to genital and pulmonary tuberculosis. These are subjects which are attracting a great deal of attention, and as there exists still a wide diversity of opinion, the subject is by no means settled. Some state that the kidney is often the seat of primary tuberculosis, and that the process extends from here to the lower portions of the urinary tract and the genital organs; others claim and maintain that tuberculosis of the urinary organs seldom, if ever, occurs as an isolated affection.

Callinet, as quoted in Senn's work on genito-urinary tuberculosis, makes the following statements: "The tubercular process may commence in any part of the uro-genital tract independently of pulmonary tuberculosis. One out of eighteen consumptives suffers from some form of genito-urinary tuberculosis."

The kidney is affected either primarily or simultaneously with other organs, namely, the ureters, bladder, prostate, and least frequently the testicles. The ureters are never attacked primarily, but always in connection with renal tuberculosis. The testicle is often the starting point of tuberculosis of adjacent organs, especially the prostate; less frequently the kidney.

The prostate and the seminal vesicles may be the seat of primary infection, but more frequently with simultaneous tuberculosis of the kidneys and testicles, in which case infection is not by continuity, but collateral.

The bladder is seldom affected primarily, but usually consecutively to kidney and prostate.

The result of investigation shows that the kidney may become infected with tubercle bacilli as follows:

First, from the blood without demonstrable tuberculosis in any other part or organ of the body, resulting in primary renal tuberculosis. The fact that the kidney is such an important eliminating organ, it is rather easy to understand how the tubercular organism can be deposited from the blood in the kidney substance, as the blood is passing through the kidney structure to get rid of its waste material. Tubercle bacilli enter the body in most instances through the respiratory or the alimentary tract. They may not produce lesions at the portal of entry, but become taken up by the blood, and easily filtered out in the kidney if they find a suitable soil.

Second, from the blood, as a secondary affection in pulmonary phthisis and tuberculosis of any other organ, namely, from a latent focus which in itself does not impair the general health, such as a cheesy bronchial gland or latent joint.

Third, by continuity of surface in ascending tuberculosis.

A unilateral tuberculosis has become a bilateral condition, the infection descending by the way of the ureter to the bladder and up the opposite ureter, a descending tuberculosis, therefore, being followed by an ascending process. In unilateral tuberculosis of the kidney the opposite organ increases in size and assumes compensatory functions.

Senn states that in nearly 50 per cent. of all cases of renal tuberculosis in men the kidney is reached secondarily by an ascending tubercular process from the bladder. On the other hand, James Israel, who is credited with having had a larger experience in renal surgery and more satisfactory results than any other surgeon, is firmly convinced from his clinical observations and the result of post-mortem examinations that primary tuberculosis of the kidney is a much more frequent affection than is generally supposed, and that tuberculosis of the bladder and the genital organs occur, in the majority of cases, in consequence of a descending tubercular process.

Steinthal found, moreover, that in twelve out of twenty-four cases the disease was limited to one kidney.

Cayla and others, on the contrary, assert that renal tuberculosis is a condition always secondary to a primary focus of tubercular infection in some other organ or tissue—lungs, skin, digestive or genito-urinary mucous membrane. And thus the subject remains unsettled, some for and others against primary infection of the kidney. The clinical course and the ultimate history of many of the cases in which nephrectomy has been done and patients recovered and remained well without evidence of any disease whatever—as in one of my cases now nearly five years have elapsed since the operation, the patient being a young woman, a perfect picture of health, weighing sixty or seventy pounds more than at the time of operation, and has suffered no inconvenience whatever since the kidney was removed, and one other case of mine remaining well and in good health now two years—makes one think that the cases were more than likely primary renal infections.

Early Diagnosis.—The beginning symptoms are very insidious in their onset and ill-defined, and scarcely to be considered pathognomonic, and consequently the true condition is very seldom recognized early. The attention is directed to the vesical symptoms first always. In all of my cases the history of illness dated over one year, and, as is usual in the clinical reports of these cases, the vesical symptoms of pain, polyuria, frequent urination persisting, with cloudy and occasional bloody urine, incessant pyuria, with the development of a tumor mass, were the prominent symptoms. The kidney symptoms rarely attract notice until after, and usually *long after*, vesical symptoms are prominent.

Pain.—There is, as a rule, some pain in the lumbar region as soon as the disease becomes pronounced. This is usually not great unless there is obstruction to the free escape of urine and tubercular products due to the tubercular process involving the ureter. In such conditions the pain is severe, paroxysmal, and extends down ureter and thigh, simulating the pain produced by stone. Sooner or later there is gradual enlargement on the side affected, which soon becomes palpable.

Tenderness.—As to tenderness, it is not usually marked, and never so acute as that elicited in cases of suppurative pyelitis or pyonophrosis. Deep pressure usually elicits tenderness over the kidney. It never fails to do so when the organ is enlarged.

Hematuria.—This is a variable symptom. It was not marked or profuse in any of my cases, nor is it ever constant. Frequently, however, it is one of the early symptoms which direct attention to the kidney.

Pyuria.—The presence of pus in the urine is not, as a rule, one of the early symptoms. After the disease has progressed and there is foci of destruction from caseation, then it is observed, and persists as a rule.

Frequent and Painful Urination.—These symptoms are noted from the start. They are misleading from the fact that they are almost always incorrectly interpreted, and a cystitis is thought to be the cause of it, and the patients are treated for such, and in that way overlook the real focus of the disease.

The age at which it most commonly occurs is between 20 and 40. Family history of phthisis is often obtained. It is negative in all but one of my cases.

Bacteriological Examination.—A positive diagnosis can be made only by recurrence to all diagnostic means, and I consider a careful bacteriological examination of the urine is one of the most important and reliable diagnostic methods at our command. There is, as a rule, in the beginning polyuria, with acid reaction. It soon becomes albuminous, and is mixed with blood, pus, and debris of tubercular tissue, with a general absence of casts. Examination of sediment for tubercle bacilli is of the utmost importance, and if, after repeated and careful search, their detection by staining is difficult or impossible, the inoculation experiments with the urine upon animals (guinea-pigs preferred) should be made. They will frequently yield results where bacteriological examination proves negative, and therefore is to be regarded as the one point which makes the diagnosis between tuberculosis and other inflammatory affections of the genito-urinary system. The smegma bacilli must not be confounded with the tubercle bacilli.

Renal palpation is a diagnostic means of great moment, and should be resorted to early and often. The presence of tubercle bacilli in the urine which is acid and containing pus, with an enlarged palpable kidney, with general impairment of health, points very strongly to renal tuberculosis.

Catheterization of the ureters by the method of direct illumination of the bladder is one of the most important methods for diagnosis, and should be used whenever possible. It enables us to secure

the urine separately from the kidneys, and in this way obtain positive evidence of both organs. This is a fair method for determining positively between a unilateral or a bilateral—in other words, an operable or inoperable renal tuberculosis. I am not at all sure, however, that it is a wise procedure to make use of ureteral catheterization in all cases. I am strongly of the opinion that in some of the cases, where it is entirely unilateral, that by passing a catheter up into the unaffected ureter and kidney there is grave danger of taking with the catheter a certain number of tubercular organisms, and in that way give rise to an infection in an organ that has previously escaped, or, in other words, convert a unilateral into a bilateral disease.

In females catheterization of the ureters is done without much difficulty. In the male, however, it is accomplished seldom and with much difficulty. The best method here is the same as in the female—by direct illumination of the bladder, or by the use of one of the various cystoscopes.

These are the principal means of arriving at a diagnosis, which, as a rule, is most unfortunately made late in the course of the disease, and therefore, on account of this uncertainty of diagnosis during the early stages of renal tuberculosis, operative treatment has not yielded the good results that we have reason to hope for in early operation.

Surgical Treatment.—The treatment for primary unilateral renal tuberculosis, I believe firmly, can and should be summed up in one word—nephrectomy. And the earlier done the better. I do not wish to convey the idea that it should always be resorted to as a primary operation, for in many cases it cannot, and therefore is only to be done as a secondary operation; but the point I do wish to lay stress on, which I think of great importance, is that renal tuberculosis is fast being recognized as a disease, the treatment of which belongs to the domain of surgery, and not to medicine. Cures, I know, have been attributed to medical forms of treatment; post-mortem records show that healed renal tuberculosis occurs and is likened to the healed tubercular cavities seen in lung tuberculosis; but, in the face of this evidence, I think it is the opinion and experience of most surgeons that if these patients are left unoperated upon there is but one ending for them, as in the vast majority of the cases it becomes a hopeless and an incurable disease. I think it the one method of treatment that offers any prospect of relief and cure. I consider it a wholly justifiable operation when limited to proper cases of unilateral tuberculosis of the kidney, where the renal disease either is primary, or, if secondary, to some other focus of tuberculosis, this primary focus not being far advanced. Spontaneous cure so seldom occurs that it might be considered never to take place. I have done nephrectomy with good results in each of my cases, and in one, I think, a part of the ureter I left in was probably infected with a tubercular process (Case IV). He made an excellent recovery and is still doing well; all of his vesical symptoms, which were very urgent, urinating every ten to twenty minutes a day and in the night, have cleared up. He has gained thirty or forty pounds. I take it that the ureter in this case ceasing to functionate since the kidney, the chief focus of disease, is removed, will undergo a retrograding process, and I hope for a quiescence of the ureter involvement. Inoculation experiments made twice were negative.

Nephro-ureterectomy, namely, taking out with the kidney most of or part of the ureter, is a better procedure, and should be undertaken where there is any suspicion of its invasion. These two radical procedures can only be offered where the surgeon can satisfy himself that the other organ is present and in a healthy condition.

Nephrotomy.—This is often done as a palliative operation, namely, a free incision into the kidney, with free drainage. It is a valuable preliminary step to a radical nephrectomy. By this means patients have been put in far better condition for the more serious operation, and it is called for in all cases where primary nephrectomy is contraindicated. In cases, for instance, where uncertainty exists as to the true condition of the other kidney, also in unilateral cases where the patient's general health has been markedly impaired from long-standing disease with a large, palpable kidney, and in no fit condition to stand such a serious operation as nephrectomy, here the operation of nephrotomy, which can be speedily done, without necessitating much shock, should always be resorted to. It is an exceedingly valuable measure, as it relieves pain by diminishing tension, and furnishes a direct outlet to the tubercular pus and material that is held within the kidney.

The constitutional symptoms are less pronounced after this, and the patient's general condition, resisting powers, etc., are markedly improved. The secondary nephrectomy can now be performed with far greater chances of success.

[CONTINUED IN NEXT ISSUE.]

TWO CASES OF CYSTIC DISEASE OF THE KIDNEY SIMULATING AN OVARIAN TUMOR.

By T. A. Ashby, M.D.,

Professor of Diseases of Women, University of Maryland.

The following cases are of sufficient interest from the standpoint of diagnosis to deserve being recorded. Those who are dealing with intra-abdominal conditions almost daily fully appreciate the difficulties which are frequently experienced in making a positive diagnosis before the abdomen is opened by an exploratory incision. In former years much stress was laid on the importance of a correct diagnosis in advance of the section. At the present time less attention is paid to the diagnosis of the condition in advance of the section, the surgeon recognizing that the question of operation is the one of chief importance and the character of the condition itself of minor consideration. So many mistakes of diagnosis are made by all surgeons that the question resolves itself into one of interference or non-interference as the proper line of action. Mr. Lawson Tait, after his first 1000 abdominal operations, came to the conclusion that a diagnosis was a matter of no importance, provided the condition warranted the surgeon in operating. His mistakes of diagnosis had shown him that it mattered little whether he had to deal with a pus tube, tubal pregnancy, ovarian cyst or other intrapelvic conditions so long as any one of these conditions required an abdominal section. He made the incision and then removed the condition, reserving the diagnosis for the last step in the operation, that is, the examination of the specimen when it was exposed on a plate. This attitude has been forced upon all operators, and there are few men today who pride themselves upon preoperative diagnostic skill. It is a matter of personal satisfaction to find in the abdomen the condition the surgeon has previously diagnosed, but beyond this there is little that is of practical value. On the contrary, it may be claimed that accuracy in diagnosis, or rather assumed accuracy, has held up more than one surgeon when a bolder man would have given the patient the benefit of doubt by making an exploratory incision to determine the real character of the condition. The more practical men become in surgical work the less uncertainty there is as to the method of dealing with unusual conditions. Experience points the way, and the surgeon follows indications rather than well-established landmarks. He relies more on his judgment and less on authority, and in this way often makes new routes of travel for himself and for those who follow him. The advance of surgery today is due to the bold and self-reliant men who have brushed aside precedent and opened up new fields of work. Within twenty years a new continent has been discovered in surgery. The land has already been surveyed and made ready for thousands of busy workers, whose duty it will be to fell the forests, clear the soil, and sow the crops for the harvesters now getting ready to gather in the golden grain. As much as the surgeon of today thinks he knows, the problems unsolved are greater than those now definitely settled. The man of busy work must see how rapidly new conditions come before him as he thinks of the results of a previous experience. Daily tests are made of his store of knowledge and experience, and he is constantly being reminded that he is working in a field so rich in unknown quantities that with all his alertness he can scarcely keep pace with the many new facts claiming his attention. The wider his experience the narrower seems his range of vision. There can be no true progress for the surgeon unless this mental attitude takes hold of him. The moment he ceases to see, to think and to perfect his methods of work, from that moment he ceases to grow. The habit of close observation of every condition and of every clinical phenomenon coming before him is essential to his progress not only in the operating-room, but in the after-treatment of his cases. Exploits with the knife, as important as they are, do not constitute the chief excellence of the surgeon. Post-operative conditions must claim the largest share of his attention if he would escape the sequelae which follow so largely in the wake of the surgeon's path. How much discredit has been cast upon surgery by post-operative results it would be difficult to determine. Ask the great body of general practitioners who have so largely to deal with this class of cases what are his most trying experiences, and an answer will be found to this question.

It must be admitted that the surgeon, in making compromises with conditions, cannot at all times be held responsible for results which are inevitable in the nature of things. What is here suggested has only a general bearing upon the conditions I shall report in connection with the cases that are the subject of this paper. What I wish to show is that a diagnosis of a condition is

not the essential step, and has comparatively little to do with the results of operative work; second, it is interesting to observe how conditions in one organ can so closely resemble those found in other organs as to make a differential diagnosis almost impossible; third, it is instructive to know that conditions so dissimilar in their pathology are closely related in their surgery and should be dealt with from the same standpoint, due reference being given to anatomical differences and relations; fourth, I wish to make no claim for doing better surgery than any well-trained surgeon of today is able to do, but want to show the progress in surgery of the kidney over that of eighteen years ago by a comparison of methods based upon an observation made in a case resembling Case 2 I have here reported.

Case 1.—Miss A., a young unmarried woman, aged 23, was admitted to the University Hospital in the spring of 1903. She was assigned to the public ward and came under my service. Upon examination two tumors, each the size of a cocoanut, were found located in the pelvis on both sides of the uterus. The left tumor was somewhat larger than the one on the right side, but did not differ from it in physical signs. Both tumors were cystic and gave all the characteristics of small ovarian cysts. In the region of the left kidney a large tumor mass was made out, and was diagnosed a hydronephrosis of the kidney. The urine was somewhat cloudy and showed pus cells, but no albumen. The urine, as was afterwards found, was at that time almost entirely the secretion from the right kidney. I decided first to open the abdomen and remove the two ovarian cysts and to attack the kidney later through an incision over the kidney region. The abdomen was opened in the median line and the right ovary was removed without difficulty. When the cyst to the left of the uterus was examined a peculiar condition was brought to light. It was found to be a largely-dilated ureter coming off from the bladder and containing over a pint of urine. With some difficulty it was disconnected from the bladder and dissected out. Following the course of the ureter it was found leading up to the kidney and was over one inch in diameter. The kidney was tapped and a gallon (estimated) of urine was drawn off from the sac. The kidney was next removed in its entirety with the ureter and dilated cyst down to the bladder. After complete removal of kidney and ureter the specimen resembled a dumbbell, the kidney representing the larger tumor and the lower portion of the ureter the smaller tumor, the intermediate portion of the ureter being about one inch in diameter and about four inches long. The portion of the ureter attached to the bladder was found almost completely closed, and only a drop of urine could pass through the orifice. This explained the damming up of the urine in the kidney and ureter and the unusual size of the two cysts. The ureteral opening into the bladder was closed over to prevent a possible leakage from the bladder into the pelvis. To remove the kidney and ureter it was necessary to lengthen the abdominal incision and to extend the upper end at a right angle toward the left. Much difficulty was experienced in removing these cystic masses. As the peritoneum was soiled by the unavoidable leakage of urine, I decided to close the abdomen and drain the lower end of the incision. This was done. The drainage retarded the progress of the case and necessitated a longer stay in the Hospital. Recovery followed the operation, and some six months after the patient had been out of the Hospital she returned on a short visit, and, meeting me in the ward, spoke to me. I failed to recognize her until she told me who she was. She had gained so much in flesh and was so improved in general health that she bore no resemblance to the young woman I had previously operated on. The origin of her condition I could not account for. There was nothing in her history to explain it. Fortunately, her right kidney was sound and had been performing the functions of both kidneys for some days prior to the operation.

Case 2.—Mrs. J., aged 40 years, mother of ten children, was referred to me by Dr. G. J. E. Sponseller of Martinsburg, W. Va., and admitted to the University Hospital June 9, 1905. Upon examination a large cystic tumor was found lying in the lower abdomen and freely movable in every direction. Its attachment to the uterus could not be made out, but it presented every physical sign of an ovarian cyst. Her urine showed normal results on examination. The patient was placed on preparatory treatment, and on June 12 was operated on. An examination made after anesthesia, and when she was in the Trendelenberg position, showed that the tumor had very wide ranges of position. It could be pushed up under the diaphragm and over the entire intra-abdominal cavity. Its pedicle could not be made out, but I still held to the opinion that it was a cyst of the ovary, with a long and narrow pedicle. After opening the abdomen in the median line the pedicle was

looked for, but could not be found attached to the uterus. Both ovaries and tubes were brought out through the incision and were found normal. The tumor was covered with omentum and intestines, and after some dissection it was found to be a large cyst of the left kidney. The tissues covering the cyst were carefully dissected away and the pedicle was found and ligated. Very little difficulty was experienced in removing the kidney and in closing over the stump of the pedicle. The weight of the kidney had elongated the pedicle to such an extent that the mobility of the organ had been increased to the degree above stated. The abdominal cavity was washed out with normal salt solution until the cavity was clean. The incision was next closed, but before bringing all the tissues together the cavity was filled with the normal salt solution, which was allowed to remain. There was no shock from the operation. The patient made a rapid recovery and was able to leave the Hospital on the twentieth day after her admission. The right kidney was sound, as was shown by the fact that the patient passed the normal quantity of urine the first twenty-four hours after operation and during her stay in the Hospital. The left kidney had undergone a cystic degeneration and also presented deposits of sarcomatous tissue. This case so closely resembles a case which came under my notice some eighteen years ago in the practice of a distinguished surgeon that I feel I may draw a comparison between present and former methods of dealing with such conditions in illustration of the progress which surgery has made in connection with kidney work. In the case to which I refer the diagnosis of ovarian cyst was made and the abdomen was opened for the removal of the tumor. When the tumor came into view it was found to be a large cystic kidney. After a few manipulations the abdomen was closed, the operator deciding that an attempt at removal would be fatal. This might have been the result, but it could have been no worse if the kidney had been removed, for on the fourth day after the section the patient died from sepsis.

At the present day the surgeon must be fully prepared to deal with all forms of intra-abdominal disease. A mistaken diagnosis will occasion no embarrassment if he is able to contend with conditions as they are presented. The surgery of the kidney, of the spleen, of the liver, of the ovary, or of the intestines is the same, taking into consideration anatomical conditions. Methods of controlling hemorrhage, of preventing sepsis, and of dealing with other surgical problems are the same, and must be employed with the same degree of care and certainty if results are desired.

THE TREATMENT OF DYSMENORRHEA.

By J. M. Hundley, M.D.,

Clinical Professor of Diseases of Women, University of Maryland.

Dysmenorrhea, or painful menstruation, is dependent upon a number of varying conditions. The fact that it is so dependent accounts in a large measure for the frequent failures encountered in bringing about a cure. There is no one symptom that demands more painstaking investigation and thought in getting at its cause than pain associated with menstruation; in fact, in some cases the cause cannot be definitely determined. The treatment offered here is for a class of cases giving the following history:

Miss K., 19 years old, consulted me in December, 1903. She began to menstruate at 14; experienced some pain with the first period. From that time, five years ago, to the present the pain has increased in severity until now she loses two days from school in each month, being compelled to remain in bed for that length of time. For the past year she has experienced pain and soreness in the lower abdomen for a week after the flow ceased. She has some leucorrhea, is constipated and nervous, appetite is variable, does not sleep well, is losing weight, and feels unable to continue her studies. She has tried various medical and hygienic measures without benefit. She is nauseated the first two days of the flow, and occasionally vomits. On vaginal examination nothing was found to account for her pain except a small, undeveloped uterus. There was no inflammatory disease. The other organs of her body were normal.

As she had tried various drugs without benefit, I dilated and curetted her uterus December 23, 1903. She was relieved of pain for four months, when the pain returned and became as severe as formerly. She consulted me again in March of this year, urging me to do something to relieve her. Having read a paper by Dr. Carstens of Detroit about that time on the treatment of dysmenorrhea by the use of the stem pessary, I determined to try it. I wrote Dr. Carstens for more specific directions in the use of the pessary and to get additional assurance from him that the pes-

sary would do no harm. I feared to allow a woman to move around having a foreign body in her uterus. In his letter he emphasized the necessity of using the pessary only in those cases free from any inflammatory disease of the tubes and ovaries whatsoever. When used under such conditions no harm had ever resulted in his hands. As this case exactly fitted the specifications in his letter, I introduced the pessary on the 15th of March. It was introduced without an anesthetic or previous dilatation of the cervix. I saw her on the 20th of June, just before she left the city for the summer. She has suffered very little pain since the introduction of the pessary, has gained in weight, and is feeling generally better.

The number of cases in which I have used the pessary (six in all) is too small to make any positive statement as to the value of the method of treatment. So far I am encouraged to continue its use in this class of cases. The pessary must never be used in the presence of inflammatory disease of the pelvic organs or fibroids of the uterus. Dr. Carstens thinks these small, undeveloped uteri need exercise. The stem pessary acts as an irritant and sets up uterine contractions. In this way the uterine muscle is increased and menstruation approaches the normal as the uterus more nearly approaches the normal-sized organ.

ABSTRACTS AND EXTRACTS

The "Lancet" on American Spelling.—Our American friends have seen fit to adopt styles of language and of orthography which seem to us to indicate a very defective appreciation of the value as a national possession of the language of Milton and of Addison, and we are not prepared to condone the neglect of etymology which is displayed in "fetal," while against "pediatrics," or "pediatrist," we must enter the most energetic protest of which we are capable. If we must have either word at all, especially the latter, it should surely be "paediatrist," should show that it is derived from *pais*, and not from *pes*, and that it is intended to mean a child's physician or surgeon, and not, as it appears to do, a corn-cutter or a bunion-cutter.

Bromides in Epilepsy.—These come nearest to specifics in the fits. In mild cases, without mental impairment and fits at long intervals, they may arrest the seizures immediately or within a brief time. A satisfactory response will be apparent within a short period, if at all. Secondly, they may induce marked lessening in severity and frequency without complete arrest. This is the common result, and may confidently be expected in the majority of cases in the early stages. Thirdly, they may change the time of seizures, converting nocturnal into diurnal attacks, or *vice versa*. Fourthly, they may exert no influence at all, or may even make the attacks worse.

They should be commenced at the earliest possible time after onset, as there is a greater prospect of arrest or improvement during the first five than the second five years. They should be continued for a period, the duration of which is to be determined by a study of each case separately, not less than two years. If benefit does not follow a daily amount of 45 to 60 grains of one, or a combination of the bromides, some other remedy or treatment should be sought. The *grand mal* is that most amenable to their influence, *petit mal* and psychical equivalents being little influenced. In serial epilepsy and status epilepticus, chloral in combination with bromides forms the most effective remedy. Belladonna should be tried in all cases where bromides have failed, now and then producing remarkable and persistent arrest. Except in combination with bromides, borax is not of great use.—*W. A. Turner, Lancet,* March 18, 1905.

Causes Contributing to Success in Cataract Extraction.—Dr. Saml. Theobald (1867), in an article on this subject before the Medical and Chirurgical Faculty of Maryland, said that 50 years ago, when "flap extraction" was in use, the most skillful operators were well content if their failures did not exceed 12 per cent. During the two decades following the introduction of Von Graefe's modified linear extraction, 8 to 10 per cent. of failures were not uncommon. And the operator whose failures exceed 4 or 5 per cent. has little ground for self-congratulation. In a compilation of nearly 2000 cataract extractions by well-known ophthalmic surgeons of this country and Europe, made by Dr. Frank M. Ring in 1895, the percentage of failures was 3.67. In 192 consecutive cataract extractions performed by Dr. Theobald, including 100 reported in the *American Journal of Ophthalmology* in December, 1899, there was a percentage of failures of but 3.12. Among the causes which have most to do with this markedly better showing are (1) the modification in the operation of cataract extraction introduced by Von Graefe; (2) the discovery

of local anesthesia; (3) the application of the principles of antiseptic surgery to eye operations; (4) the skilled nursing now at command; (5) the improved hospital facilities; (6) the provision against post-operation accidents afforded by such contrivances as the protection shield of the late Dr. Russell Murdock, and (7) the more definite specialization of eye surgery. Still better results might be obtained could we guard absolutely against infection—which, in spite of careful antiseptic precautions, occurs about twice in 100 operations—and were our patients, usually well advanced in life, in sound health, were their eyes free from complicating diseases, and were they always as tractable as the operator could wish. The intractable patient sorely taxes the patience and skill of the most expert operator.

DEATHS

Dr. W. A. Moale, class of 1879, died in this city on July 11 after an operation for acute appendicitis. Dr. Moale was born in Baltimore in 1849. He was educated in private schools in this city and at the John Hopkins University. For six or eight years after graduation in medicine he took an active interest in medical and scientific work and gave evidence of great natural gifts and of a high order of attainments. He filled the chair of orthopedic surgery in the Baltimore Polyclinic and was one of the most active supporters of that movement in the city. The Polyclinic was conducted for several years with enthusiasm and success in South Baltimore. Dr. Moale's interest in the institution will be recalled with pride by his old associates. He showed unusual zeal and capacity for professional work, and gave his time and money most liberally to the poor who came to his clinic. After the withdrawal of Dr. Moale and other associates from the Polyclinic in 1884 the work languished and then died out. Dr. Moale soon afterwards withdrew from all professional work to give his attention to his large business interests. He had inherited a handsome fortune, which was increased by his sound judgment and intelligent business enterprise. To those who knew him well he was a genial, loyal and helpful friend. He will be greatly missed in the social and business life of the city.

Dr. George H. Morgan, class of 1864, died at his home in Morganton, N. C., on July 11 at the age of 66 years. Dr. Morgan was born in Baltimore. After graduation he was appointed an assistant surgeon in the U. S. Army and assigned to duty at Fort Monroe. At the close of the war he was mustered out of service and began the practice of his profession in this city. After a few years he re-entered the army and was ordered to Morganton, N. C. He was next assigned to the Sixth Cavalry and stationed in Arizona. After four years of service he resigned from the army and took up his residence in Morganton, where he continued to practice until his death. He was the physician to the School for the Deaf and Dumb in Morganton and one of the surgeons to the Southern Railway for the district extending from Salisbury to Asheville. He occupied a prominent place in his profession and was greatly respected by all who knew him. He is survived by a wife, two daughters and one son.

Dr. W. K. Carroll, class of 1873, died on July 20 in Arrow, Col., where he had gone for treatment for tuberculosis. He was born in Baltimore August 18, 1851, and resided in the city during the first 10 years after graduation, but was never actively engaged in the practice of medicine. He owned a beautiful estate near Queenstown, Md., and during the past 20 years has lived on his farm, giving much attention to agricultural interests. He was devoted to the use of the rod and the gun, and a few years ago came near losing his life from an explosion of a gun. Dr. Carroll was a gentleman of quiet and simple manners and habits, a kind friend and useful citizen. He was an uncle of Mayor Timanus of Baltimore.

Dr. James F. McShane, class of 1870, died at his residence in Baltimore on August 1, after an illness extending over two years and a half. Dr. McShane was educated in the public schools and subsequently graduated from Loyola College in this city. Soon after graduating in medicine he became identified with the Health Department in this city and was appointed vaccine physician, and later he was appointed Assistant Commissioner of Health, which position he filled under several administrations. He succeeded Dr. George H. Rohe as Health Commissioner and held the position about eight years. His long association with the Health Department made him a very capable Health Commissioner. He was always courteous and considerate towards members of his profession and was a most popular official. Dr. McShane is survived by five sons and two daughters.

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EDITORIAL

DISTINGUISHED ALUMNI OF THE UNIVERSITY. In the issue of the BULLETIN of July 15 brief notices of a number of the distinguished alumni of the University were published. In the present issue these notices are continued. It is the purpose of the BULLETIN to continue this list as long as it is possible to locate the alumni who fill important positions in the medical, social or business world. Whilst men who are engaged in teaching, or who hold important positions of trust, may be said to occupy distinguished positions, these positions are not the only ones which entitle members of the medical profession to special distinction. On the contrary, the ranks of the profession are filled with men who have reached even higher places of usefulness and honor in the profession than those who hold chairs in medical schools or positions in connection with medical institutions. The BULLETIN does not mean to draw distinctions, but will attempt to make known to its readers every graduate who has followed his profession with honor and usefulness, or whose influence and worth as a man and citizen entitle him to recognition. The large majority of the graduates of the University are busy practitioners scattered over this entire country and a few are located in foreign countries. In the search which the BULLETIN is making for them they are found occupying important places and engaged in useful and successful work. The mail is bringing almost daily letters from these old graduates, which tell a story of loyalty to the old University which is most encouraging. The work which the BULLETIN is doing in locating and corresponding with the alumni will make itself manifest as each issue appears. The undertaking is a laborious one, but it will bring its returns. The object the BULLETIN has in view is to bring all of the graduates of the University in closer relations with their Alma Mater and to make them better known to their old associates. The interest which this work has already stimulated is a revelation to the editorial staff. It is an indication that the graduates of the University still have a warm affection for and strong personal interest in her welfare. It is believed that this interest will grow from month to month, and that many who have not taken a personal interest in the University since graduation will take pride in the new life and spirit which now dominate the institution. As the University will soon celebrate its centennial the BULLETIN proposes to keep this event before its readers with the hope of arousing an interest in the occasion which will be in keeping with its importance.

Another purpose of the BULLETIN must not be lost from view. We refer to its value as a medium for the publication of original matter, reports of cases, correspondence and abstracts of articles published by the alumni in other publications. Its columns are opened to every graduate of the University, and all are not only invited but urged to contribute to its pages. We believe this feature of the BULLETIN will make it one of the most useful mediums among class publications and an advantage not presented by any publication within our knowledge. With the growth of circulation and patronage the size of the BULLETIN will be enlarged and new features will be added. It is not proposed to follow a narrow and selfish policy in its relations towards other institutions or other publications, but to show that all have the right to exist and that the good of the profession must come from the high character and usefulness which each exerts in its special field of endeavor.

BALTIMORE AS A CENTER OF MEDICAL EDUCATION.—The daily press of this city has recently devoted considerable attention to a discussion of the claims of Baltimore as a business and manufacturing center, and has attempted to show that business and manufacturing interests can be conducted at less expense than in cities to the north of Baltimore. The expense of rentals, of labor and of conducting business has been shown to be far less than is paid in other cities of like population and commercial standing. The advantage of trade has been shown to be in favor of Baltimore, and our business people are urged to reach out for the trade which has gone elsewhere, but

which legitimately belongs to this city. The different commercial and trade organizations here have taken up the suggestions made by the press and an active movement is now being made to influence business to this city. No one can question the importance of an organized movement in the directions indicated and the great value of well-directed efforts in bringing forward the claims of Baltimore as a place of residence, of business, or of trade. All the claims made for the business interests of the city are equally applicable to her educational interests. Baltimore has numerous advantages over other communities as a center of education, which should be made more widely known to the outside world. Her central position, mild and temperate climate, the hospitality of her people, the cheapness of living, with the richness and abundance of her markets, and the social and moral characteristics of her citizens make her an ideal home for the student. With all of these advantages Baltimore has an educational plant in the location, size and equipment of buildings and in the character and qualification of her teachers that cannot be equaled by many other communities. As a center of medical education her claims will compare with those to be found in any city in America. There is here the greatest abundance of clinical material accessible to the student. There are a large number of well-equipped hospitals and dispensaries and many well-trained men who can give instruction to the medical student. The growth of this city in its student population within recent years is an illustration of the advantages here offered. It is the opinion of the BULLETIN that the time has come when the medical schools of this city should come together and organize a movement looking to a wider advertisement of these advantages. Why should not the medical schools follow the example of the commercial organizations of the city in this effort to attract attention and to draw patronage? Is there anything more undignified in acting as a unit than in seeking patronage in an individual capacity? Are medical schools conducted now as semi-charitable institutions or as business organizations? Is the standard of a school lowered by seeking to attract students? The BULLETIN will only answer these questions by making one line of argument. It holds to the opinion that organized effort in commerce, trade and in education will bring about reforms, correct abuses, improve conditions and make for progress much faster than is made under conditions where competition is subjected to no restrictions or regulations. It is possible for the schools of this city to get together on a basis that will be mutually advantageous and will result in the raising of standards and in the improvement of conditions which will make Baltimore a leading medical educational center of America.

ALUMNI IN MARYLAND.—The BULLETIN has the names and addresses of 384 graduates of the University of Maryland who reside in the city of Baltimore and of 364 residing in the State, or a total of 748 in the State at large. The number of physicians living in Maryland is given by Polk's Directory as 2162. This record shows what a strong influence the University should exercise over the profession of Maryland. The BULLETIN believes that the vast majority of these graduates are loyal to the old University and that their interest and pride in their Alma Mater will assert itself when it is shown that the University has a just claim to their influence and affections. It will be the purpose of the BULLETIN to show that whilst some of her graduates may not be in close touch and sympathy with the University, those in present management of her interests have nothing but the kindest regards and best of wishes for all of her graduates.

SHORT SKETCHES OF DISTINGUISHED ALUMNI OF THE UNIVERSITY OF MARYLAND.

Dr. I. R. Trimble, class of 1884, is Professor of Anatomy and Clinical Surgery in the College of Physicians and Surgeons of Baltimore; Surgeon to the Baltimore & Ohio Railroad, and Surgeon-in-Chief to the United Railways & Electric Co. of Baltimore. Dr. Trimble is one of the most active and industrious surgeons in this city, and ranks among the most successful, professionally and socially. He enjoys both popularity and influence. The future holds out to him many opportunities for advancement.

Dr. John Whitridge Williams, class of 1888, is Professor of Obstetrics in the Johns Hopkins University. He is also a Fellow of the American Gynecological Society. Dr. Williams enjoys a distinguished reputation as author and scientific investigator. His recent textbook on obstetrics is a most valuable work, and entitles him to the highest rank as an author and teacher. He is among the most widely known of the younger members of the profession in the United States.

Dr. Joseph A. White, class of 1869, is Professor of Ophthalmology in the University College of Medicine, Richmond, Va. Dr. White is widely known as a specialist, and is the leading surgeon in this line of work in Richmond, where he has resided since 1879.

Dr. Henry M. Thomas, class of 1885, is Clinical Professor of Nervous Diseases in the Johns Hopkins Hospital. Dr. Thomas is widely known as a specialist, and has already reached a distinguished position among the neurologists of this country.

Dr. J. Ford Thompson, class of 1857, is Professor of Surgery and Clinical Surgery in the Columbian University, Washington, D. C. For a number of years Dr. Thompson has been recognized as one of the leading surgeons of the nation's capital, and has also enjoyed an international reputation. He has been a most active and useful man in his profession, and is most highly esteemed for his eminent ability and high-toned character.

Dr. Samuel Theobald, class of 1867, is Clinical Professor of Ophthalmology and Otology in the Johns Hopkins University; founder and Ophthalmic and Aural Surgeon to the Baltimore Eye, Ear and Throat Charity Hospital. Dr. Theobald has reached the highest distinction in his specialty, and is widely known as a teacher, author and clinician. He comes from a family of distinguished physicians, being a grandson of the emperor, Dr. N. R. Smith, and a greatgrandson of the distinguished surgeon, Dr. Nathan Smith. The mantle of these illustrious men has fallen on him. He is a gentleman of the most genial nature and of the highest attainments and character.

Dr. I. S. Stone, class of 1872, is Professor of Clinical Gynecology in the University of Georgetown, Washington, D. C. Dr. Stone is a Fellow of the American Gynecological Society, and is distinguished as a writer, teacher and clinician in diseases of women. He has energy, force and ability, which place him in the front rank among the leaders of his specialty in America. Dr. Stone is an ex-President of the Alumni Association of the University of Maryland and a loyal friend to his old Alma Mater.

Dr. E. Miller Reid, class of 1864, is Professor of Diseases of the Nervous System and of the Throat and Chest in the Baltimore University, and also President of the Faculty. Dr. Reid was an assistant surgeon in the United States army during the latter part of the Civil War. He enjoys a successful practice and is highly respected and esteemed by those who know him.

Dr. Robert L. Randolph, class of 1889, is Associate Professor of Ophthalmology and Otology in the Medical Department, Johns Hopkins University. Dr. Randolph is well known as an author and clinician, and ranks among the distinguished specialists in this country. His original papers have been of marked value and have attracted wide attention. An essay on "The Role of the Toxins in Inflammation of the Eye" was awarded the Boylston prize of Harvard University, 1892.

Dr. A. C. Pole, class of 1876, has filled the Chair of Anatomy in the Baltimore Medical College since 1884, being one of the founders of this school at the time of its reorganization and one of its most useful teachers. Dr. Pole is a gentleman of such quiet and unassuming manners and habits that only those who know him intimately are able to judge of his attainments and ability. He enjoys a large and remunerative practice, and is respected and loved by those who know him as a man and conscientious Christian. His unostentatious charities and benevolent nature entitle him to universal esteem.

Dr. H. O. Reik, class of 1891, is an assistant in Ophthalmology and Otology in the Medical Department of the Johns Hopkins University and Surgeon to the Eye, Ear and Throat Charity Hospital of Baltimore. Dr. Reik is one of the most prominent and progressive of the younger members of the profession in the State. He has already taken a high rank in his specialty as an author and clinician, and has honors assured him as he advances in the line of promotion ahead of him. He has been most active in the work of reorganization of the Medical and Chirurgical Faculty of Maryland along the lines established by the American Medical Association.

Dr. W. L. Robins, class of 1890, is acting Professor of Nervous Diseases in the Medical Department of Columbian University, Washington, D. C. He has made rapid advances in his profession, and is forging to the front rank among the physicians of his city. He holds numerous hospital appointments and positions of trust such as only come to men of energy, ability and upright character.

Dr. Charles H. Riley, class of 1882, is Professor of Obstetrics in the Woman's Medical College of Baltimore. Dr. Riley is a most successful and able obstetrician and gynecologist, having served for one year after graduation as an interne to the Woman's Hospital of New York, and for some years being an assistant surgeon to the Woman's Hospital for the Women of Maryland. He is a practitioner of large experience, sound judgment and skill. Personally, he is a most genial and lovable gentleman, loyal in his friendships, charitable in his opinions, and liberal with his money and service to all who make proper claims on him. To enjoy the confidence and association of such a man is a fortunate privilege. Would that there were more men of his class in the world!

Dr. John B. Schwatka, class of 1891, is Professor of Diseases of Children and Clinical Medicine in the Maryland Medical College. He is also the Dean of the Faculty of his College, and has been a most active and efficient agent in the upbuilding of this institution. Dr. Schwatka is an ex-Surgeon-General of the State of Maryland and an ex-sheriff of the city of Baltimore. He has taken an active interest in the political as well as professional life of this city, and has an influential following both as a citizen and physician. With his ability, force and aggressive personality the future promises him both honor and success.

Dr. W. A. B. Sellman, class of 1872, is Professor of Gynecology in the Baltimore University. Dr. Sellman is a specialist of long and large experience, both as teacher and practitioner, having held the chair of gynecology in his school since its organization in 1884. He is a member of the American Association of Obstetricians and Gynecologists, and is a frequent contributor to its annual volume of *Transactions*. Dr. Sellman has a textbook on gynecology now in press, which will no doubt add to his present high reputation as a specialist.

Dr. J. Frank Crouch, class of 1890, is Professor of Materia Medica and Therapeutics in the Baltimore Medical College, and assistant surgeon to the Presbyterian Eye, Ear and Throat Charity Hospital. Dr. Crouch, soon after graduation, acquired a large general practice, which he abandoned some six or seven years ago for special work in eye, ear and throat diseases. He has made rapid progress in his specialty and is recognized by the profession and public as an able and skillful surgeon.

Dr. N. G. Keirle, class of 1858, is Professor of Pathology and Medical Jurisprudence in the College of Physicians and Surgeons of Baltimore. Dr. Keirle is also director of the Pasteur department of the City Hospital. He is widely known and distinguished for his scientific work and learning. He is a gentleman of genial and unassuming manners, of great kindness of heart and warm attachments. Those who know him best love and admire him most. He is an unselfish, enthusiastic, scientific worker.

Dr. George A. Fleming, class of 1884, is Professor of Diseases of the Eye and Ear in the Woman's Medical College of Baltimore. Dr. Fleming is surgeon to the Presbyterian Eye, Ear and Throat Hospital and ophthalmologist to the Good Samaritan Hospital. He is among the most successful specialists in his line of work in this city.

(To be Continued.)

NOTES AND ITEMS

Dr. Edward Borck, class of 1863, has practiced his profession for many years with distinguished success in St. Louis, Mo. Dr. Borck has been a voluminous writer and an able contributor to the literature of his profession. He is one of the most widely-known surgeons in the Mississippi Valley. In a recent letter received by the BULLETIN from Dr. Borck, he says: "I always enjoy hearing from my adopted home, Baltimore, and my Alma Mater. My work is done. Infirmities of 71 years of age prevent me from active work; nevertheless, I am always interested in my beloved profession." The BULLETIN is always glad to receive communications from the alumni and hopes that Dr. Borck will favor it with an occasional article.

Dr. Arthur E. Ewens, class of 1904, is practicing his profession at Atlantic City, N. J., in association with Dr. Metzler.

Dr. P. H. Tawes, class of 1904, is located at Tylerton, Somerset county, Md.

Dr. J. Robert Lowery, class of 1904, is located at Cool Spring, N. C. The nearest physician to Dr. Lowery is 12 miles distant. His isolated position should teach him habits of independence and

self-reliance, which may be of value to him in his professional career.

Dr. William Davison, class of 1876, has practiced his profession since graduation in Middletown, Frederick county, Va. Dr. Davison has led a most useful life and has been a most successful practitioner. His field of work is in the beautiful valley of the Shenandoah and embraces the battlefield of Cedar Creek, fought October 19, 1864, between the armies commanded by Generals Jubal Early and Sheridan.

Dr. H. C. Cline, class of 1876, has practiced his profession since graduation at his old home, Front Royal, Va. During the Spanish-American War Dr. Cline held a commission as surgeon in the U. S. Army and was stationed for some time in Cuba. Dr. Cline has never married.

Dr. C. B. Boyle, class of 1869, has practiced his profession for many years in Hagerstown, Md. Dr. Boyle is a gentleman of most unassuming and quiet manners and is greatly beloved and respected by the people of Western Maryland. He is an occasional visitor to the University Hospital and holds a tender feeling for the old University.

Dr. John B. Bagby, class of 1893; Dr. William F. Creasy, class of 1890; Dr. B. R. Gary, class of 1891; Dr. W. B. Smith, class of 1899; Dr. F. D. Willis, class of 1897, are among the leading physicians of the enterprising and rapidly-growing city of Newport News, Va. The University of Maryland is fortunate in having such a large number of representatives among the physicians of that city, which has at this time a population of between 25,000 and 30,000 people, and is destined to be the greatest shipbuilding center on the Atlantic coast.

Dr. David M. Smouse, class of 1876, is professor of gynecology in the College of Physicians and Surgeons (Medical Department, Drake University) at Des Moines, Iowa. Dr. Smouse is one of the best-known specialists in the Northwest and is prominently identified with the medical interests of his State.

Dr. Oliver T. Jones, class of 1880, is professor of obstetrics in the Medico-Chirurgical College at Kansas City, Mo.

Dr. Eustathius Chancellor, class of 1877, and formerly an assistant resident physician in the University Hospital, has been located for many years in St. Louis, Mo. He is one of the prominent physicians in that city. Dr. Chancellor was formerly professor of genito-urinary diseases and syphilis in the Beaumont Medical College. He is prominently connected with the various life-insurance companies of his city. He has given special attention to radiography and electrotherapeutics during recent years.

Dr. Henry C. Sutton, class of 1880, is city health officer of Rome, N. Y., and physician in charge of the Rome Charity Hospital, physician to the Central New York Deaf and Mute Hospital and local medical examiner for the leading life-insurance companies doing business in that city.

Dr. W. C. McCreeby, class of 1887, is a distinguished specialist of eye, ear, nose and throat diseases, and is located at Syracuse, N. Y.

Dr. W. F. Wegge, class of 1886, formerly superintendent of Northern Hospital for the Insane at Winnebago, Wis., is now located in Milwaukee, Wis., and prominently identified with the medical interest of that city.

Dr. E. J. Waddy, class of 1891, is located at Waterloo, Iowa.

Dr. Edward Sanborn Smith, class of 1900, is practicing his profession with great success at Macon, Mo. Dr. Smith is visiting surgeon to Blees Military Academy, city physician, Macon, Mo., and member of the Missouri State Medical and Macon County Medical and Surgical Societies. Dr. Smith writes to the BULLETIN as follows: "Hurrah for the man who thought of the BULLETIN! It has been the crying need of the alumni of the best medical school in the country. I have learned more of the doings and whereabouts of my classmates since reading this number (referring to July 15th issue) than I ever knew before. I hear from the 10 or 12 in the army, but the others were lost to me."

From a personal letter recently received by a member of the editorial staff from Dr. Randolph Winslow, who has been in attendance on the meeting of the American Medical Association, held at Portland, Oregon, during July, the BULLETIN takes the liberty of publishing the following

extract: "I expect to leave for Alaska tomorrow night (July 17), to be gone about 10 days, and I suppose I shall be home in about three weeks. I am going to San Francisco and thence home. I have had a very pleasant trip this far. The meeting of the association was quite large and the proceedings of the surgical section animated. About a dozen from Maryland were present. I read a paper, and at the conclusion two men at once came to speak to me. One was Oscar Stansbury, my classmate, who lives in California and is much thought of and prosperous; the other was Otto S. Binswanger, class of 1882, who has lived in Portland ever since graduation, and is professor of chemistry in the Medical Department of the University of Oregon. Drs. A. A. Matthews and Morris Robbins were also there. The country here is great, but largely wild. The cities Seattle, Spokane and Tacoma are all fine and doubling in population. I came here over the Northern Pacific and return by the Southern and Union Pacific. If I live to get back I shall have traveled about 10,000 miles. I have enjoyed the time very much, but feel very much like getting home. Give my love to all the boys and girls."

Dr. John Szlupas, class of 1891, has practiced his profession since graduation in Philadelphia with distinguished success. In addition to a large medical work, the Doctor has labored with great zeal in the literary field, but almost exclusively in the Lithuanian language. He is the author of many pamphlets and books bearing upon the history of the Lithuanians. The BULLETIN begs to acknowledge the first volume of the History of the Lithuanians written by Dr. Szlupas, which will be deposited in the library of the University. As the Doctor says, "There may not be many men who will be able to read it, but the University shall have the record that one of its pupils has not spent his life in vain, but, besides a busy practice, has aroused a sleeping nationality to a new life and, so I hope, to a prosperous future."

Dr. C. B. Irwin, class of 1904, located soon after graduation in Kansas City, Mo. Dr. Irwin has made a recent visit to the University of Maryland and speaks most encouragingly of his professional outlook in the West.

Dr. J. Howard Iglehart, class of 1903 and recent chief resident physician to the Maternity Hospital, has been appointed lecturer on osteology in the Woman's Medical College of Baltimore, and Dr. H. E. Ashbury, class of 1903, radiographer at St. Joseph's Hospital and assistant surgeon to the Hospital for Crippled and Deformed Children, has been made lecturer on electro-therapeutics and instructor in orthopedic surgery in the same institution.

Dr. H. Cook Davis, class of 1902, has been made clinical professor of diseases of nose and throat in the Woman's Medical College of Baltimore.

Dr. J. R. Abercrombie, class of 1895, has been elected professor of materia medica and dermatology in the Woman's Medical College of Baltimore.

In the publication of Notices of Distinguished Alumni, a few errors have been made in giving titles, growing out of the fact that changes are constantly made from session to session, and recent catalogues showing these changes have not come into our possession. Dr. A. D. McConachie's title should read professor of materia medica and therapeutics and clinical professor of eye and ear diseases in the Maryland Medical College. Dr. W. H. Price is now professor of diseases of children in the Maryland Medical College. The BULLETIN will take pleasure in correcting any errors which it may make in connection with positions held by graduates of the University. The object of these notices is to show the important work the alumni of the University are doing in various educational institutions.

The following physicians have been recent visitors to the University Hospital:

Dr. J. S. B. Woolford (1896), Chattanooga, Tenn.

Dr. J. H. McDuffy (1897), Columbus, Ga.

Dr. W. E. Arthur, Street, Md.

Dr. R. A. Hammond, Jessups, Md.

Dr. D. Prevout, French cruiser Jurien de la Graviere.

Dr. F. T. Brooks, New Windsor, Md.

Dr. Frank Arthur, Cardiff, Md.

Dr. J. D. Wallace, Mt. Holly, N. C.

Dr. A. F. Hardt, Williamsport, Pa.

Dr. R. O. Crisp, Boswell, Pa.

Dr. H. C. Robinson (1904), Grantsville, Md.

Dr. W. B. Gambrill, Alberton, Md.

Dr. W. T. Wootton, class of 1898, has recently been appointed a member of the Federal Medical Board at Hot Springs, Ark. Dr. Wootton is a native of Montgomery Co., Md., and a son of Dr. Edward Wooton, a graduate of the University and a recent member of the Senate of Maryland. After graduating from the University in 1898 Dr. W. T. Wootton entered the U. S. Army as surgeon with rank of captain and was assigned to the 27th Volunteer Regiment and later was assigned to the 21st Regulars. He served two years and six months in the Philippines.

BOOK REVIEWS

Addresses and Other Papers. By William Williams Keen, M.D., LL.D., F.R.C.S. (Hon.). Philadelphia and London. 1905. Illustrated. Occasional Addresses and Other Papers. Published in response to numerous requests.

We cannot give the titles of the twenty-five papers in this handsome volume of 441 pages. They are all upon medical subjects, and deal with a variety of themes—history, anatomy, vivisection, surgery, education, biography, endowment, death, etc. Among them we find that delivered in this city at the commemoration of the Centennial of the Medical and Chirurgical Faculty of Maryland in 1899, and entitled "The Debt of the Public to the Medical Profession." These addresses are all admirable and inspiring; they emanate from the leading surgeon, perhaps, of the western hemisphere; they are healthy food for the mind. But there is one especially that we wish to recommend to our medical students for its high moral tone, one which at the time of its first appearance in the *Philadelphia Medical Journal* of June 6, 1903, struck us most forcibly. It is upon "The Qualities Essential to Success in Medicine." "I have never known a man to fail of achieving an honorable or even enviable success," says Dr. Keen, "who had four characteristics—first, a good, moral character; second, good manners; third, perseverance, and fourth, studiousness."

E. F. C.

The Vermiform Appendix and Its Diseases. By Howard A. Kelly, A.M., M.D., and E. Hurdon, M.D. Philadelphia and London. 1905. Royal 8vo., pp. 827.

This great work, occupying several years in preparation, is the most complete monograph on the subject extant. It deals exhaustively with the history, anatomy, physiology, bacteriology and treatment of the appendix. The authors have had the aid of many others, and the staff of artists at the Johns Hopkins Hospital are conspicuous in the 399 original illustrations, some in colors, and three lithographic plates. Kelly's work is laborious and thorough in everything he undertakes, and this, his latest treatise, will form the chief reference upon the appendix and its diseases for a long time to come. It is dedicated to Professor Halstead. The following quotation from M. H. Richardson at the beginning shows the present appreciation of the subject: "I am firmly convinced that appendicitis is the most important acute abdominal disease of the present time."

E. F. C.

Multiple Personality — An Experimental Investigation. By Boris Sidis, M.A., Ph.D., and Simon P. Goodhart, Ph.B., M.D. New York. 1905. 8vo., pp. 462.

This investigation into a most curious and remarkable phase of mental phenomena is interesting and suggestive. What is individuality? How shall we explain multiple individuality? We must seek a solution in the nervous system, the neuron organization. The case of Rev. Thomas C. Hanna, who, after a fall, succeeded by unconsciousness, lost his primary personality and acquired a new one, was made the subject of careful and prolonged scientific investigation. Ultimately recovering, the two personalities merging into one personal consciousness, he has minutely detailed his experience during this interval, when for all intents and purposes he became an entirely new individual, "a new-born baby," who had to be taught the simplest operations of life. We are told that but one other case of complete double consciousness is upon record, and the Hanna case is the first which has been under direct personal observation and experimental control.

E. F. C.

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NEPHRECTOMY FOR RENAL TUBERCULOSIS, WITH A BRIEF REPORT OF THIRTEEN CASES OF NEPHRECTOMY; MORTALITY FOLLOWING OPERATIONS NIL.

BY FRANK MARTIN, M.D.,

Clinical Professor of Surgery, University of Maryland.

(Continued from last issue).

Again, this preliminary opening of the kidney by side-tracking the urine from that kidney, enables one to know more of the true condition of the other kidney by examination of the urine alone, and avoid, if it is a male patient, the very difficult process of catheterization of the ureter. I venture to say that the vast majority of nephrectomies that have been undertaken in the past upon male patients, at any rate, have been performed without previous catheterization of the ureters having been resorted to.

Various statistics are given as to the curative effect of the operation as well as to the mortality attending it by different operators. We find very few surgeons who have more than a small number to record. The general opinion, however, is that a primary unilateral renal tuberculosis, like a local tuberculosis elsewhere, when once thoroughly removed, offers fair and the only prospect of cure.

Primary nephrectomy is the operation of choice. It is undoubtedly a serious operation and attended with a high mortality. This fatality of the operation I believe to be due often to the fact that the cases have not been carefully examined and well selected, and in this way bilateral involvement exists unrecognized at the time of operation; consequently anuria (or complete suppression of urine), which, next to shock, is the chief danger following this operation, is more readily explained. Shock I believe to be due almost entirely to hemorrhage during operation. I find I can have long operations without shock if all bleeding points are controlled.

This inability on the part of the remaining organ to compensate for the functional activity of the removed organ and perform the entire work of both occurs, however, very frequently, even when the opposite kidney is not affected, and is to be considered the most serious condition and danger attending nephrectomy. This is to be kept in mind and guarded against before operating by always ascertaining the competence of the kidneys as to the amount of urea.

Mortality.—The mortality varies with statistics of the different surgeons. It has been high following all nephrectomies. For instance, in a table of nephrectomies given by Newman ("Surgical Diseases of the Kidney," 1888, p. 437), out of 324 nephrectomies performed for various surgical diseases, including tumors, there were 123 deaths, or a percentage of 37.96. Senn reports five cases of nephrectomy for renal tuberculosis—two recoveries and three deaths. Two deaths resulted from uremia two days after operation. In the two cases recovered apparent permanent cures followed the operation—one two and the other four years after operation.

Falklam, as quoted in Senn's work, gives 40.9 per cent. as the proportion of permanent cures. He collected 88 cases of nephrectomy for tuberculosis, of which 25 died from the immediate effects of the operation.

Adams, of Chicago, is credited with 57 nephrectomies, of which 11 were made through the abdomen, with a mortality of 36.3 per cent.; 46 by the lumbar route, with a mortality of 28.2 per cent.

Newman is credited with collecting 33 cases of nephrectomy for tuberculosis, with 12 deaths; mortality 36 per cent.

A report in a recent volume of the "Annals of Surgery" from Roosevelt Hospital, New York, gives mortality 31¼ per cent. in nephrectomies performed during last 10 years.

Technique of Operation.—First, as to the incision or the method to be used in removing a tuberculous kidney. Most surgeons prefer the lumbar or extraperitoneal route, as distinct from the intraperitoneal or transperitoneal route. The comparison usually made between these two meth-

ods is based on the percentage of mortality or the comparative mortality statistics.

These different routes or incisions have to meet circumstances of widely different degrees of gravity, and where a very large kidney, such as a sarcoma will produce, it is many times impossible to remove it by the lumbar method. So with progressive improvement in surgical details of abdominal operations, the anterior or transperitoneal incision for nephrectomies has been advancing in favor.

It is the operation of choice in large solid tumors, and another advantage it certainly possesses is the facility with which the other kidney may be felt, and its existence as well as its condition determined. Of course, this can be and has been determined in another way, namely, by a separate incision of small size through the opposite side of the abdomen, palpation of the kidney made, and the wound closed. Again, it has its advantages in cases where extremely extensive adhesions bind the kidney down.

It is contraindicated in the presence of suppurative disease, and if performed under these circumstances should be almost always followed by lumbar drainage.

Many surgeons have a preference for a certain incision. There are three places at which the incision may be made—in the linea alba, linea semilunaris, and in the lumbar region, and are variously described as the vertical incision of Simon's, König's, Kocher's, Lagenbuck's, etc. It is unnecessary to cite further these methods. The one I have used is something like König's. I made a long incision running parallel with the lower border of the twelfth rib and one-half inch below it, beginning about two inches from the spines of the vertebrae and extending obliquely downwards and forwards across the iliocostal space to well below the anterior superior spinous process of the ilium, and further, if necessary, and especially if the ureter is to be followed down and removed. This incision extends through the entire muscular layers of the abdominal wall, skin, superficial fascia, external oblique, internal oblique, and transversalis muscles, down to the peritoneum. The peritoneum is left intact and carefully dissected away from the lateral wall of the abdomen, and carried over by means of large retractors towards the median line. If it is accidentally opened, it can be closed by fine sutures, or at this stage it may be opened purposely and a gloved hand passed in to explore and ascertain as to the presence and condition of the other kidney.

It has been stated that the only absolute proof of the presence of the two kidneys consists in feeling both of them. The opening is now closed, the kidney uncovered, extraperitoneal, the peritoneum being stripped over towards the median line, and its vessels and ureter tied off separately. The ureter can be followed down quite to the bladder and removed if necessary. I have found this a most excellent method, and by placing a large pad under the opposite side of the patient the iliocostal space is widely opened, thereby enabling one with this incision to obtain a large opening to work in. All vessels can be seen readily and secured before being cut, and the entire dissection goes on with very little loss of blood. The renal vessels are freely uncovered, and can be tied comfortably without being pulled and dragged upon with the fear of tearing into the vena cava. This has happened, patient dying from hemorrhage on the table. I have had in two of my cases the aorta freely uncovered and lying in the bottom of the wound. This method also gives best results in cases where perinephritic abscesses have occurred or where nephrotomy had been previously done, and as a consequence the kidney is tied up by dense adhesions.

In conclusion:

1st. I maintain that clinically we do have primary renal tuberculosis, which very frequently is unilateral.

2d. That by careful diagnostic efforts this condition can be recognized early.

3d. Separation of the urine by catheterization of the ureters should be resorted to where any suspicion exists.

4th. That as soon as the diagnosis is made nephrectomy offers the only prospect of cure.

CASES ARE REPORTED IN THE ORDER IN WHICH THEY COME, SO THEY ARE NOT CLASSIFIED BY ANY DEFINITE HEADING, BUT SIMPLY REPORTED IN ROTATION.

Case I. — Large renal calculus. Kidney tuberculosis. Operation: Nephrolithotomy, later nephrectomy—lumbar route. Cured.

J. W. H., male, aged 43; occupation, manufacturer; was admitted to University Hospital September 3, 1897.

Family History.—Tubercular history on father's side of family.

Previous History. — Had swollen testicle 12 years ago. Five years ago had an attack of gravel, with pain in left loin, extending into the groin and

left testicle, accompanied by chills and fever; was laid up. Since then has had repeated attacks less severe, not causing him to be confined to his bed, but followed by sore feeling in back. Has never noticed blood in urine during the entire time; general health not markedly impaired.

Present Illness.—Patient dates present trouble back about 12 weeks, when he began to have pain and soreness about the region of his left floating rib; this grew steadily worse.

Physical Examination.—Marked pains on pressure over the left kidney; no tumor felt in kidney region, but distinct sense of resistance.

Examination of Urine.—This showed albumen, pus, epithelium, pus cells in abundance, acid reaction, specific gravity 1020, and amount in 24 hours 750 c. c.; temperature 98°, pulse 74.

Diagnosis.—Possible stone.

Operation.—September 4, 1897; chloroform; oblique lumbar incision parallel to the last rib. Before exposing the kidney I came upon a small perinephritic abscess. I then exposed kidney, and found a track running into the organ. The kidney substance was incised from end to end, and a large branching stone was found extending into the calices, filling the pelvis, and a prolongation one inch in length down into the mouth of the ureter. Stone dried weighed 340 grains. Wound partly packed with gauze and a drainage tube placed in the pelvis of the kidney, and wound sutured lightly around gauze. Patient reacted well. Amount of urine first 24 hours extremely low—350 c. c. This improved, and patient convalesced rapidly. Kidney tissue showed evidence of destructive process going on, and in the dressing a number of large, disorganized fragments came away. Scrapings examined showed tubercle bacilli in abundance.

Nephrectomy Operation.—About three weeks after the stone was removed a nephrectomy was done and the tubercular kidney taken away. Wound healed by granulation. Patient left Hospital October 18, with a small sinus still at site of operation. Report four years following operation is that he remains in good health.

Case II. — Primary unilateral tuberculosis of kidney, left. Operation: Primarily nephrotomy, later secondary nephrectomy — lumbar route. Cured.

Mary L., single, aged 14, white, female; was admitted to Hospital April 22, 1898.

Family History.—Negative; no tubercular history.

Previous History.—Patient has always been regarded as delicate; had diseases incident to childhood, and pneumonia twice; first attack eight years ago, last one five years ago. No symptoms relating to urinary tract noted in history.

Present History.—Last October, 1897, patient began to lose flesh rapidly and a cough developed; until January, 1898, this cough lasted. No urinary symptoms noticed up to this time; no hematuria, pyuria, or painful or frequent urination noted in history. Was confined to bed in December, having fever every day and pain in left loin of a dull aching character. Vesical symptoms, with frequent urination, were now noted. An enlargement was noted in the region of spleen and left loin about this time. In February her physician, Dr. V. M. Reichard, opened the swelling in loin and evacuated four ounces of pus. The opening was drained, but patient did not improve, and temperature still ran an irregular course, patient becoming extremely emaciated.

Physical Examination. — Tenderness over left kidney and a moderate swelling in left lumbar region, where a small sinus was noted. Patient very weak and frightfully emaciated. Urine turbid, acid, and specific gravity 1014. There was pus, albumen, epithelium, urates, pus cells in abundance; stained specimen, as regards tubercle bacilli, negative.

Blood Examination.—Showed marked leucocytosis.

Operation.—April 23, 1898; chloroform. An oblique incision was made in left lumbar region, exposing kidney, which was very much enlarged, and a sinus was found running into substance of kidney. Upon opening kidney it was found disorganized, and numerous foci through the body of kidney were opened up, evacuating a large quantity of thick, cheesy pus. In opening up the last of these foci there was all at once a great gush of blood, which pressure did not at first control, and it looked as though the renal artery or vein had possibly been torn. A nephrectomy was thought of to control the hemorrhage, but patient was so very weak that such a procedure at that time would have been more than likely fatal; and as packing very tightly seemed to be controlling it, I relied on it, and put off nephrectomy for later operation. Patient rapidly improved and gained in general health, and wound closed except sinus into kidney.

Pathological Report. — Scrapings from this sinus showed tubercle bacilli in abundance.

Urinary Report.—As made by Dr. Adler, just prior to the removal of kidney, made with the view of obtaining the condition of the supposed well kidney, is as follows:

Examination May 31: Amount of urine in 24 hours 880 c. c.; amount of urea 16.1 grams.

Examination June 1: Amount of urine in 24 hours 1280 c. c.; amount of urea 24.38 grams.

Examination June 2: Amount of urine in 24 hours 1020 c. c.; amount of urea 22.4 grams; total nitrogen 12.639 grams.

Microscopic Examination. — Examination for tubercle bacilli was negative; no casts.

After the operation of incising kidney, owing to the condition of the patient, it was impossible to obtain the total daily amount of urine passed, so that quantitative urea and total nitrogen determinations could not be made. The percentage amounts were obtained and were about normal. The urine obtained was probably from the healthy kidney alone, as the pelvis of the diseased kidney was opened and the urine secreted flowed out of the wound in back. This probably explains the negative result of examination for tubercle bacilli.

Operation. — Nephrectomy—lumbar route, or extraperitoneal method; June 7, 1898. A large incision was made on account of the kidney being of large size and densely adherent everywhere from previous operation. The peritoneum was pushed forward, and in separating adhesion from it I opened it in two places, but sutured it up with fine silk. The kidney was dissected free from the peritoneum and brought up into wound; ureter ligated low down first and then the vessels; wound was tucked with sterile gauze and left open, save a few sutures put in at corners of wound. Patient made an uninterrupted recovery.

Measurements of Kidney When Removed.—The kidney was twice its normal size, 13 cm. from inferior to superior border, 7 cm. from anterior to posterior surface, 9 cm. from internal to external border. On making section of kidney it was found riddled with large tuberculous abscess cavities. The kidney tissue was entirely destroyed.

Examination of Urine After Operation.—No pus, no albumen; repeated examination of urine for tuberculosis negative; inoculation test not made.

Wound Healing.—By granulation. Patient left Hospital July 5, wound almost entirely healed.

Subsequent History.—Improved rapidly in general health, and reported in January last, 1899, as entirely well, having gained 38 pounds in weight. No evidence whatever of tuberculosis.

Note: October, 1900.—Now two and a-half years after operation, patient is reported by her physician as being in perfect health.

Note: Patient died from perforated appendix and general peritonitis at University Hospital three or four years after the kidney was removed, being perfectly well in the interval. She was operated on during my absence by Dr. Winslow.

[CONTINUED IN NEXT ISSUE.]

INFANTILISM.

By H. Richardson, M.D.,

Pathologist to the Maryland Asylum and Training School for Feeble-Minded Children; Lecturer on Physiologic Chemistry, and Clinical Lecturer on Neurology and Psychiatry, University of Maryland.

Arrested physical and mental development in children is a condition which has received but little attention from physicians until recent years. The family doctor is continually consulted about a child who has ceased to develop either physically or mentally. The anxious parent receives but little satisfaction, except that it will probably develop later on. Even if the child does improve, he rarely becomes normal, the years of development which he has lost never being regained.

Infantilism arises from various causes, some of which are amenable to treatment, others are due to conditions of such a nature that but little can be done to assist nature; but many apparently hopeless cases can be greatly benefited by careful treatment. One of the most common causes of non-development, both mental and physical, is incompetency of the digestive functions. It is evident that if the growing organs do not receive sufficient nutrition their development must be arrested and imperfect. Derangements of the stomach secretions are often accountable for dwarfed growth and enfeebled mentality. There may be little or no symptom of gastric indigestion, the child often having a large but dainty appetite, with a chronic diarrhœa; in other cases the diet has to be most carefully regulated to prevent severe attacks of colitis. In these cases a reduced secre-

tion of hydrochloric acid is the primary cause of the trouble. The secretion of hydrochloric acid is of paramount importance for perfect assimilation, as not only is it necessary for the gastric digestion, but it is its presence in the duodenum which stimulates the pancreatic and biliary secretions to flow into the intestine.

Byrom Bramwell records a case of a boy of 18, with the development of 12 years, who was subject to chronic diarrhea. From examination of the stools it was found that the pancreatic secretions were defective. Under treatment his diarrhœa ceased, accompanied by rapid mental, physical, and genital development.

The liver is an organ which bears the brunt of the digestive process during prenatal life, defending the fœtus from the maternal toxins which pass the placenta. If the mother has suffered from any infectious or diasthetic disease during pregnancy, the child's liver is apt to be enlarged, perhaps even cirrhotic, at birth. In any case, cell exhaustion will exist to a greater or less extent from the excess of chemic work which has been forced upon the organ. The liver, even in the normal child, has proportionately more work than that of the adult. It is, therefore, of great importance that it should be in the best possible condition to perform its multitudinous processes. Chronic and persistent constipation often occurs in these cases, which must not be combated with drugs, but by diet and exercise. No matter what may be the etiologic factors of the infantilism, stimulation of the hepatic function is good treatment.

Syphilis accounts for but very few cases of mental deficiency, but it often has a very marked effect upon the physical development. As the syphilitic lesion is usually in the vessels, attention to the circulation and dilation of the vessels is indicated.

Parental alcoholism accounts for a considerable number of cases of non-development as well as for physical deformities. If either of the parents or both are under the influence of alcohol at the time of coition, marked enfeeblement of the offspring may result. It must, however, be remembered that a very large number of children are conceived under these conditions, by far the larger majority being normal. The treatment of these cases is not attended with much success.

The effect of failure of the thyroid secretion upon mental and physical development has recently received great attention. Cretinic and cretinoid conditions have been described at length. Many cases which 15 years ago would have been sent to an ayslum have been made comparatively well and capable of more or less mental work. The congenital cases are usually easy of diagnosis, and if thyroid is given with alkalies, improvement almost invariably takes place. There are, however, a number of cases in which the thyroid lesion is post-natal, the result of some infectious disease, which are more difficult to diagnose, the development arrests varying with the condition of the child at the time of the attack and the amount of thyroid deficiency which has been produced.

Roger has shown that measles, scarlet fever, diphtheria, typhoid fever, cerebro-spinal meningitis, smallpox, and purulent peritonitis may produce pathologic conditions in the thyroid gland, partially destroying its function. The history of these cases shows that the child developed normally until one of the above-named diseases appeared. After convalescence the child ceased to grow physically and mentally; he remains short for his age and childish mentally. Most marked of all is the non-development of the sexual organs, boys of 18 and 19 years of age not being more developed than a child of 12, without any sign of pubic hair.

The writer was called to treat a boy of 19 years of age who was 4 feet 6¼ inches tall and weighed 76 pounds. The family history pointed to alcoholism in both parents. There was a decided reduction in the caliber of the arteries. The mean blood pressure was 174 mm. Hg. and the maximum 218 mm. Hg. There was marked accentuation of the second sound of the heart; the liver was small. The genitalia were infantile. After one year's treatment he measured 4 feet 11½ inches and weighed 96 pounds.

N. F., 20 years of age, gave the history of having measles at 2½ years of age, followed by severe convulsions and progressive dementia. She was having five or six epileptoid attacks in the 24 hours, and had ceased to talk, having the intellect of a low-grade idiot. She showed a fairly typical picture of cretinism. On the administration of thyroid her convulsions were reduced to one or two a week, and her mentality is improving. This is only the second case in the writer's experience where thyroids have been of benefit in convulsions; usually they aggravate the attacks. There are other causes of infantilism, one of which is not uncommon—due to congenital reduction in the size of the blood-vessels. These cases of angioplasia are usually perfectly and symmetrically formed and of good mentality, but short of stat-

ure, having the appearance of a man as he appears through the wrong end of an opera glass. But little can be done to improve these cases. Ateleiosis and other forms of infantilism are described in "The Thyroid and Parathyroid Glands," Blakiston & Co.

The etiologic factor in arrested mental and physical development is often difficult to detect, but in all cases, in the writer's opinion, attention to the digestive and hepatic functions, with thyroid feeding, should be tried, and will generally be rewarded by improvement in the general condition and by increased development.

THE GOVERNMENT CONTROL OF PROSTITUTION IN DENMARK.

By Hugh W. Brent, M.D., and Ejnar Hansen, M.D.

The discussion of prostitution has always been confined to special works on the subject and medical publications.

It is unfortunate that the general public should manifest such antipathy to general distribution of ethical knowledge concerning one of our greatest evils.

One of the surest ways of guarding the community against its evil effects is to educate the people in regard to its dangers.

The instant a plan is adopted, just as soon is a great cry raised by a certain element whose delicate sensibilities have been shocked by the bare mention of the existence of public women, who would regard it as an unspeakable breach of morals to openly discuss such a subject.

The road of the crusaders would indeed be rocky, to say nothing of the boulders of caustic criticism rolled down from the virtuous (?) heights above. Unlike the Arabs, they would be unable to "silently fold their tents and depart in the night," but would more likely have to beat a hasty retreat in the glare of the lights of those who know best what is good for the people, or think they do at least.

The position occupied by the youth of the land is, in some respects, like the man in the wolf-infested forest by night. Especially is this true in regard to his knowledge of prostitution. It is something which he has known as a thing unmentionable, not to be thought of, much less talked about by refined people.

His father has probably imparted to him much advice in regard to the economic and religious world, but in all probability not a word of the pitfalls of the social evil. In school he has received a smattering of physiology—mostly the exaggerated pictures of the injurious effects of alcohol—but there it has ended.

Probably in all his career he has heard nothing of prostitution and venereal diseases, except the secret whisperings of his companions in the streets. What ideas have in this way become fixed in his head? Probably, first, that venereal diseases don't amount to much anyhow. They can be easily cured (?) by the corner druggist, and that's an end of it.

Of the remote results he is, as a rule, absolutely ignorant. His knowledge of public women being generally derived from those who consort with such, he has conceived the idea that, though, of course, it's not exactly right, still the ease with which his new-born desires may be gratified and the proverbial curiosity of the human race, lead him to indulge in practices which may, with one fell blow, ruin his future life, his future wife and his children.

The picture does not, of course, apply to all boys, but the average youth, knowing little of the dangers and less of the results of these things, is fortunate indeed if he escapes them. Then, again, take the average boy, and in an intelligent and simple way tell of the dangers of prostitution to his own health, the morals of the community and the sanctity of the home, and in all probability that boy will at least try to avoid indulgence in such a vicious pastime.

This, however, is not the work of the medical man. He can only advise and instruct when necessary. It rests with the fathers of the nation whether their sons shall enter this critical period of life armed with a knowledge which will at least give them a chance to save themselves, or enter it groping about in the darkness of ignorance, only to realize by bitter experience the whirlwind they have reaped.

The day has not yet arrived, it seems, for the enlightenment of the young generation in this way. But as the human mind broadens and the dire results more and more forcibly impress themselves on the community, let us hope that at least most parents will see the advantage of it. In the meantime it is the duty of the State and the medical profession to protect, as far as it lies in their power, the people from the train of social and physical ills which follow in the wake of prostitution.

It is agreed that prostitution can never be suppressed. Measures innumerable for stamping it out have been tried, from the harshest military to the gentlest religious, with no effect. It still flourishes after all these years, the roots so firmly entwined around each fresh advance of civilization that even in this enlightened age no abatement can be perceived.

Denmark has been especially active in her efforts to minimize the dangers of the existing evil. As early as the latter part of the thirteenth century efforts were made in this direction and have continued, with many changes, until the present time. The fight has been an extremely interesting one, and represents the efforts of men prominent in State and medicine.

Before proceeding further the authors wish to sincerely thank Prof. Edward Ehlers, the eminent dermatologist of Copenhagen, for his personal observations and papers. Without these it would have been difficult to describe past, present, and future attitudes of the State in regard to the control of prostitution. In many instances much of the original matter in his works regarding the law has been translated and used verbatim.

We owe also to Dr. Ehlers' courtesy the opportunity to see the actual working principles of the law in the police clinic for prostitutes and the Genito-Urinary Hospital.

Before describing the law now in existence, which will in all probability be changed next year, it might be of interest to cite a few of the old Danish laws on the subject. At times the law has been extremely strict, with harsh penalties; at other times it has been more tolerant.

OLD DANISH LAWS.

King Hans of Denmark in 1496 ordered that "all prostitutes or public women shall wear a cap, half red and half black, and the material of their garments shall not cost more than 25 cents a yard."

The government tried early to isolate prostitutes, forcing them to live in certain houses in specified streets, and to wear "such clothes as would distinguish them from good women." They were, however, protected by the law against the attack of people with "stick or sword."

The early law also decreed that "anyone who parts with money, clothing or jewelry in such a woman's house will not be assisted by the law to recover it."

Peter Plade, the well-known bishop, 1503-1560, says of public women and those who consort with them: "Such people should be sent to Copenhagen, Roskilde or Kallundborg, where there should always be kept 20 or 30 knouts to be used on them, because it is better that a few should be whipped than the whole land be overrun with disease and bad blood. Where there is a 'Devil's Woman' you might as well have a wolf among your children. Many "Devil's Women' are sitting around in Copenhagen and the smaller towns, and you must be careful, because they have bad beer in their pails. That beer contains syphilis and other bad things, and the young man who goes to her will be infected body and soul."

King Christian III says in his "Law of Copenhagen," 1537: "The married man who commits adultery shall lose his head. The married woman who commits adultery shall be placed in a sack and drowned."

Two years later this harsh penalty was lightened by the "Law of Odense:" "The culprit for the crime of adultery shall first be fined; if the offense be repeated, the culprit's lands will be confiscated and he (or she) will be banished; for the third offense the culprit will lose his (or her) head."

King Frederick II writes in 1574 to the chief magistrate of Elsingnor as follows: "We have heard that in your city there are living many prostitutes, attracted by the numerous foreign sailors passing through the Sounds. We order you to find all these women and give them a whipping at the public post and banish them from the city. If they return, cut off both their ears, and if they come for the third time, sew them up in sacks and drown them."

The laws of today are elaborate, and aim chiefly to prevent the spread of venereal diseases by the isolation, inspection, and compulsory medical treatment of public women.

Theoretically, they are excellent and should do much good, but, unfortunately, like many things which promise much from a theoretical point of view, they are found to be sadly lacking when put to the practical test. During the next year they will be supplanted by a new system, from which much is hoped; but, of course, only time can determine their value.

The system now in operation is known as the "Police Control." All the known prostitutes are registered in the police books, submit to compulsory examination by the police surgeon, and are restricted in certain ways.

The law is fully laid down in the "Control Book," with which each woman is furnished. It is as follows:

POLICE CONTROL BOOK. — CITY OF COPENHAGEN.

Essentials of the Law for Police Surveillance of Public Women.

Copenhagen, March 9, 1877.

Part I.—The surveillance of prostitutes is under the control of the Third Police Inspector, and he, in turn, is under the control of the Chief of Police.

Part II.—Every woman in the Control must comply with this law and the ordinary police laws.

Part VII.—Every woman in the Control must have a Control Book, for which she must pay. In these books she will find the special laws regarding her position as a public woman.

On the first page shall be her full name and date of entrance to the Control. On the second page the different days she must appear for examination, and possible changes of these days. On the last page places of residence.

Part VIII.—The public woman must at all times have this book in her possession, and must exhibit it to the sanitary police on request. To pawn or lend the book is strictly prohibited. If this book is lost, the Third Police Inspector must be immediately notified. He will furnish a new one.

Part X.—Every public woman must have the Police Inspector's permission to change address.

Part XI.—No public woman can retain her own child after four years of age. Under no condition may she maintain or care for any other woman's child. She must not have a male acquaintance living with her. She must not receive visits from minors. She must not receive security for payment from any of her clientele. She must not share her room with another woman. The sanitary police may examine her rooms at any time—day or night.

Part XII.—The public woman shall carefully avoid disorderly conduct and immodest actions on the street or in public places. Especially is it forbidden public women to show themselves in immodest or gaudy dress, to speak to people, follow them or call them by word or sign.

They are not to sit in windows or loiter in the street outside their dwellings.

They are not to walk together on the street or in public parks.

Public women may only occupy seats specified by the police in theaters and places of amusement.

It is forbidden them to sit at tables in restaurants, cafes, etc.

Public women are never to appear in the main streets or squares after 12 M.

Part XIII. — It is strictly forbidden public women to address a patron or a patron's relations on the street for payment of debt. They should ask, and will receive, the assistance of the police.

Part XIV.—No public woman shall leave the city limits of Copenhagen for more than 24 hours without the permission of the Chief of Police. Before such permission shall be given she must be examined by the police surgeon.

Part XV.—As soon as a woman suspects she has a venereal disease she must immediately report to the police surgeon or the Genito-Urinary Hospital, and there surrender her Control Book, which will forthwith be sent to the Chief of Police, with the intelligence of her admission.

Any public woman admitted to any hospital for non-venereal disease shall surrender her Control Book.

Part XVI.—If a public woman is unable to be present at the regular examination on account of sickness, she must, on the day set aside for her, send to the Chief of Police a certificate from her physician, stating that no venereal disease exists, and the nature of her malady.

Or she may get permission from the Chief of Police to be examined in her home.

Part XVII.—If a public woman shows by wedding certificate that she is married, her name will be immediately removed from the police books.

Part XVIII.—If a public woman wishes her name withdrawn from the Control list, she must inform the Chief of Police of her contemplated place of residence and occupation. The Chief of Police will forward her application to the Police Board, and they will decide the question.

If the police are not satisfied that her conduct in the future will be good, she will be placed on probation for three months, and then, if her conduct has been exemplary, her name will be erased.

Part XL.—Each public woman shall be examined by a police surgeon at least twice a week.

Part XLI.—Extra examinations shall be complied with as often as the Chief of Police deems necessary, but such examinations do not excuse from the regular examinations.

Part XLII.—The ordinary examinations are held in two designated places and at the City Hall.

Examinations may be made in the woman's house, but such permission can only be granted by the Chief of Police.

He may also recognize, if he desire, the certificate of a reputable genito-urinary specialist. Such recognition may at any time be withdrawn.

Part XLIII.—Any public woman not present at the regular examination, and at the same time absent from her home, will be arrested, taken to police headquarters, examined, and sent to jail.

Part XLIV.—A public woman interfering with the police surgeon's examination is sent to the Genito-Urinary Hospital for observation.

Part XLV.—After each ordinary or special examination the police surgeon shall inscribe in the woman's Control Book and the police books her sanitary condition. If disease exists, the extent of it, and necessary remarks. All this must be recorded by the examining physician personally.

Part XLVI.—Every public woman suffering with venereal disease shall be immediately committed to the Genito-Urinary Hospital, with a certificate from the police surgeon, stating the nature of the disease and its location.

If the diagnosis is doubtful, she is to be kept in the hospital until a decision is made.

Part XLVIII.—A public woman who is told that she has a venereal disease, and then runs away, will be arrested, sent to the hospital until cured, and then committed to jail. Any public woman found suffering from a venereal disease without having informed the police surgeon will, if he thinks she has been aware of her condition, be punished.

Any woman knowing she has a venereal disease, and continuing her occupation, will be sent to jail.

Part XLIX.—As long as a public woman is in the hospital her Control Book will be kept by the police, and not returned until she has been discharged cured. In the hospital they are considered prisoners.

Part L.—Public women must carefully follow the sanitary rules given them by the police and hospital surgeons.

Part LII.—For extra examination a fee is charged. For ordinary examinations at least one of the stations shall be free.

Part LV.—The fee for examination at the pay station shall be either 25 or 50 ore (8 or 16 cents), depending upon the time and place of examination.

Part LVI.—Any woman in the police books who disregards these laws outside of Copenhagen may receive the same punishment as if the rule were broken in the city.

Part LVII.—For infractions of these laws the punishment may be a fine of 100 kroner ($26), prison on water and bread for four days or on usual prison fare up to 16 days, or 24 days at hard labor.

BY-LAWS.

Public women must not walk in the main streets or squares after 12 M. They must occupy the last row of seats in the galleries of theaters.

The streets upon which they are allowed to walk are mentioned in the book, as are certain other restrictions in places of amusements.

The examination of the women is conducted in the following manner: There is a large waiting-room, on entering which each prostitute is given a metal disk with a number corresponding to the one in her Control Book.

Three are admitted to the examining-room at a time. The police surgeon inspects first the mouth and throat. If no lesions are found, she mounts the examining table, the externals are rapidly examined, and the urethra "milked" for pus. Two examinations are made each week, and at least one of these the cervix and vagina are examined with a Ferguson speculum. If there are no clinical manifestations of disease, she drops the metal disk in a box, has her Control Book stamped, and is free to go.

The time of each examination is about half a minute. On the morning we were present 64 women were examined in a little over a half-hour.

Of these 64 women, two had active secondary syphilis in the shape of vulvar mucous patches; two had tertiary lesions of the tongue, and one a tertiary lesion of the vagina. Clinically, there was no gonorrhea. The ages varied from 18 to 50. Several of the women have been on the books since the Control was instituted in 1877.

All this is galling in the extreme to those on the books, and one can readily see why only 600 of Copenhagen's 6000 or 7000 prostitutes are found in the police books. Of course, as soon as any prostitute is caught her name is put down, but naturally it is difficult to apprehend them. Also, in the words of the French, 'La prostitution clandestine est la source principale de la syphilis."

So here is one great defect in the system—it has no jurisdiction over the dangerous majority of public women.

Four hundred years ago Gaspard Torelli, bishop of Sardinia and private physician to Cæsar Borgia, maintained that syphilis or the "French disease" could be swept from the face of the earth if all syphilitics were isolated and kept so until cured.

It was not until a much later date that they were definitely divided into two separate and distinct maladies. All prostitutes who have been engaged in their occupation for any length of time are suffering from acute or chronic gonorrhea. It may vary from those violent acute cases to the mildest forms of chronic infection, limited to the deep cervical or Bartholins glands. It may be impossible to microscopically demonstrate the gonococcus, and from a clinical standpoint no opinion of any value can be advanced. But these mild cases are perfectly capable of transferring a very violent infection to the man exposed. Many men are infected from women in whom we cannot clinically or microscopically diagnose gonorrhea. Therefore we see that the control is absolutely helpless in regard to gonorrhea. No guarantee of freedom from liability to infect can be guaranteed by the examination.

In this we see another evidence of the great importance of the existing law. Theoretically, we should be able to diagnose gonorrhea in the female, but, as all gynecologists will agree, this is in many instances impossible after the subsidence of the acute symptoms. Then, again, the women try with every trick at their command to deceive the police surgeon. Douches are taken just before coming to the clinic and a tampon inserted, to be removed before entrance into the examining-room. Urination just before examination removes the secretions from the urethra. These faults might be obviated by confining the women several hours before examination, but this is not practical.

As these methods remove in nearly every case the clinical manifestations of the disease, and it is impossible in such a large clinic to examine microscopically in all cases, the difficulties of diagnosis may readily be seen.

In regard to syphilis, the Control accomplishes something, but leaves much to be desired.

Statistics and records have shown that if a woman is not syphilitic in the beginning she almost invariably acquires the disease during her first year in the Control.

As soon as a woman is found to be suffering from a venereal disease she is at once committed to the Genito-Urinary Hospital. In the hospital she is a prisoner. This hospital accommodates 120 patients. The arrangement is excellent, the wards light and airy, and the food plain, but substantial. On the third floor are two large well-lighted rooms for examination and treatment. The patients assemble in an ante-room, and as their names are called walk into the room for treatment, are examined, cared for by the physicians, and returned to their wards. Syphilis is treated almost exclusively by inunctions of the usual mercuric ointment.

Those suffering from gonorrhea are discharged when all clinical symptoms and signs have disappeared and two consecutive microscopical examinations of secretion from the urethra, cervix, and Bartholins glands have been negative.

The syphilitics are discharged when all clinical manifestations have subsided. It is obligatory, however, that they return at stated times for medicine and continue the treatment until pronounced cured.

Just here is a great breach in the efficiency of the Control against syphilis. The women are discharged uncured. It would be a little too vigorous to confine a woman for two or three years in order that the entire treatment be carried out. So these women go out, have a fresh outbreak of syphilis, infect more men, and are returned to the hospital. This may be repeated a number of times. These women are allowed to act as prostitutes during that period of the disease when it is most dangerous.

It is now recognized that the tertiary lesions of the disease are to a certain extent infectious. There are many recorded instances of infection from ulcerating gumma. The situation of these lesions, as a rule extra-genital, is probably the reason that they do not more often communicate the disease. In a case of Dr. Ehlers' a woman was infected by a small ulcerating gumma of the penis occurring nine years after the primary infection. There was no doubt as to the tertiary character of this lesion.

The public woman is, therefore, a source of danger to the community long after the first stages of her ailment, and may infect men at intervals for years.

The proportion of prostitutes and fresh infections of syphilis each year are just about the same as they were nearly 30 years ago when the present law was passed. There have been three rather marked epidemics of syphilis in Copenhagen dur-

ing the past half-century. No cause for this can be ascertained.

The "Police Control" of venereal diseases, therefore, though theoretically strong in every particular, has been found to be most inefficient.

Looking at it from a social point of view, the women on the books are much oppressed by the stringent measures and rules, which deprive them of many pleasures and legitimate pastimes. They must live in certain streets and houses. The prices of board is consequently high in these places, and they must make quite a sum of money to even clothe and feed themselves decently.

Having been found so eminently deficient, the Control will be replaced by laws governing only the actions and care of those suffering from venereal disease, playing no favorites—the same alike to high and low classes of the community, for in this way only can it be of any benefit.

There will be no special restrictions placed on public women other than those of the ordinary police regulations. They will enjoy the same privileges that they do in English-speaking countries.

The sanitary control of venereal diseases will include both sexes, and be in the hands of the physicians, with the understanding that, if necessary, they may invoke the aid of the police. Leprosy, diphtheria, scarlet fever, measles, etc., are controlled in this way; why not venereal diseases?

The party guilty of infecting anyone knowingly may not alone be punished by imprisonment, but must also pay the infected person's doctor's bill and reimburse him or her for any loss resulting from bad health or inability to business resulting from the disease.

All people suffering from venereal disease must take active and continuous treatment until cured.

Patients treated by a physician in compliance with this law need not have their names mentioned to the authorities unless they lapse in their treatment. The physician will then hand the name to the police, and arrest will follow.

Since 1789 Denmark has had a law by which genito-urinary diseases are treated free in all hospitals. If a patient's condition is such that he may infect others by contact or intermediate objects, even though exercising precaution, he may be forced to go to a hospital for treatment.

Any physician treating a case of syphilis may order the patient to return at certain intervals after being discharged cured to determine whether there has been any recurrence of the disease. If he does not comply, he may be forced to come to the police surgeon.

Any physician treating a patient for venereal disease must carefully explain the danger of infecting others and the penalties of the law should this occur.

Women under 18 years of age must not live in a house of prostitution.

It is now thought wrong to punish these girls by imprisonment. They are warned and sent back to their parents. If this does no good, they are to be committed to industrial institutions, where they will cultivate a clean mind and suitable occupation.

Most of these young prostitutes make their *debut* when 15 or 16 years old. So by taking them at this time it is to be hoped that they may become useful members of the community.

Under the new law patients to genito-urinary clinics may demand an examination by a physician of their own sex.

There will be opened in the poorer sections of the city dispensaries, where physicians of both sexes will be found to examine patients.

The law in regard to forced detention of prostitutes in the Genito-Urinary Hospital until all clinical signs and symptoms of venereal disease have disappeared will in all probability not be altered.

The new law departs from the old law in such a way that it can't be said: "It is a law written by men against women." Both sexes are equally liable.

Under the old law it was "that woman who does so and so;" under the new law it's "any person, male or female," who does so and so. The Danish Government hopes the benefits will be great. Anyhow, it will be given a fair trial, but past experiences forbid the expression of extravagant hopes.

In America, the "land of the free and the home of the brave," can anything be done in this way?

Our country is indeed the land of the free in every way. Sad to admit, the license for spreading venereal disease seems to be regarded by many of the inhabitants as one of their special privileges.

As the cries of the injured are not for their ears, and most of them are ignorant of the dire results to the community, it doesn't take a very case-hardened conscience to quiet any qualm of shame for their action should such a thing arise.

Only too often do those who cry loudest of American valor and bravery, in the same hour infect some luckless woman with a disease which

may either unsex her or render her a hopeless invalid for the rest of her days.

The problem is indeed a serious one, with practically no control or method of regulating the action of those suffering from venereal diseases. Our cities are being filled with sterile men, our homes with sexless women, our insane asylums with the results of tertiary syphilis, not to mention the early graves of unhappy women, cut off in the flower of young womanhood, the unavoidable result in a certain percentage of the hundreds of serious intrapelvic operations for the ravages of the deadly gonococcus.

What punishment is too severe for the despicable cur who carries home to his innocent, unsuspecting wife a vile disease, which may rob her of the hope of maternity, the God-given right of every woman, the thing for which she was created and should hold above all others as her most priceless possession? And, on the other hand, what right has any man to burden the world with his syphilitic children, monuments to his own follies and lack of chivalry in asking anyone to share his sins with him?

There are exceptions, of course—men who truly think they are cured; but many, many of them insist on marriage when they know they are hopelessly and criminally unfit for it. For these the laws of a great and good land provide no penalty. If there is a penalty, it is kept moldy and dusty in some obscure corner, with no hand to bring it forth.

But the day is coming, and let us hope it will not be in the too distant future, when we will follow Denmark's courageous example and provide suitable punishment for these transgressors of human laws. Let us hope that the days of the individual are numbered who comes home, infects the whole family with syphilis, and receives no rebuke.

We cannot hope to save the prostitute and *roué,* but we can at least do our best to render them harmless. The gonorrhea and syphilis of the innocent is the thing to be remedied. Let the strong arm of proverbially blind justice protect the home and its ties, not look on and on and far over the tragedy which is being played around the very doors of her temples. It will do no good to temporize. When the stroke is begun, see that it is all-embracing.

"The fox is soon caught that has only one burrow," and you may rest assured that we are dealing with one who has many loopholes for escape.

Horsens, Denmark, August 5, 1905.

LITERATURE.

1. Udtog af Regulativ for Politieto Tilsyn med offentlige Fruentimmer i Kjobenhavn.

2. Ehlers: "Bidrag til Diskussionen af Prostitutionssporgsmaalet."

3. Ehlers: "Regeringens ny Prostitutionsforslag."

4. Ehlers: "Prostitution et Maladies Vénériennes en Danemark."

CORRESPONDENCE.

To the University Bulletin:

The occurrence of the Fifty-sixth Annual Session of the American Medical Association, in conjunction with the Lewis and Clark Exposition, at Portland, Ore., afforded me the coveted opportunity of visiting the Pacific coast of our country and of extending my wanderings into the remote territory of Alaska, and I take pleasure in acceding to the request of the BULLETIN for some account of my trip.

Leaving Baltimore at 10 o'clock on the morning of July 5 on the Royal Blue Limited for Chicago, I was fortunate in having as traveling companions Drs. C. M. Billingslea, U. S. A., recently returned from the Philippine Islands, and now stationed in Kansas, and Marshall L. Price, formerly assistant resident physician at the University Hospital, and now practicing his profession in this city. Our train was most luxuriously equipped, and the picturesque ride over the mountains of Maryland and Pennsylvania and through the busy cities and towns on the Potomac and Allegheny rivers to Pittsburg was very enjoyable.

At 9 A. M. the next day the 831 miles between Baltimore and Chicago had been covered, and we were free to look around the great city on the shores of Lake Michigan until the evening. I spent the greater part of the day in revisiting Jackson Park, the site of the great exposition in 1893, and was most charmed with this beautiful pleasure-ground, with its magnificent waterways and lovely lawns. Some of the exposition buildings still remain and add attractiveness to the scene, while the Spanish caravels still proudly float in an inland harbor within the Park. In close proximity to the Park Chicago University is situated on a splendid boulevard, with ample grounds and quadrangles and spacious and beautiful buildings. Quite a number of students, male and female, were still in attendance, and I under-

stand the courses of instruction continue the whole year, with the exception of September. I find there is considerable jealousy between some of the other institutions of Chicago and the University, and am told "an oleagenous haze pervades the atmosphere," which is excessively unpleasant to those who are not so fortunate as to be connected with this favored school.

Leaving Chicago at 6 P. M., by way of Milwaukee, the next morning early we were in St. Paul, where the Northern Pacific Railroad begins its long journey across the continent. St. Paul and Minneapolis, the twin cities, are large, handsome and prosperous places at the head of navigation on the Mississippi river, the former the capital of the State, and the latter the seat of the University of Minnesota, one of the largest and most advanced institutions in the country. Passing the Falls of St. Anthony, our route lay along the upper reaches of the Mississippi river, and then in a northwesterly direction through a country dotted with lakes and waterways, forests and well-cultivated fields, until the Red River of the North is crossed at Fargo, and we are in North Dakota. This is a prairie-like country, nearly devoid of trees, but with the fields rapidly assuming the golden color of the ripening grain, alternating with the vivid green of the growing maize. The farms are large and the landscape is punctuated with the fine red barns, whilst the frugal farmer and his family occupy the little cottage. The western part of North Dakota is exceedingly rugged, and is cut up into hills and mounds of fantastic shape. The country is treeless and uncultivated, and is known as the "Bad Lands," and was formerly the scene of many bloody frays with the Indians, but so completely have the Indians been controlled that one can now traverse this whole region without getting sight of one. The railroad for many hundred miles follows the course of the Lewis and Clark trail along the Yellowstone river, through a country uncultivated, owing to scarcity of water, but growing grass sufficiently for pasturage, and we see large droves of cattle, sheep and horses on the ranches as the train goes swiftly by. Here, also, perhaps, we see civilization in some of its rudest phases, the habitations being either log cabins or dugouts in the sides of hills, or tents, and the population sparse. Eastern Montana presents much the same appearance as the contiguous parts of Dakota, and we pass near the battlefields of Custer and Miles and by stations bearing the names of these famous Indian fighters. As we go still farther west the country becomes mountainous, and white-capped peaks glisten in the setting sunlight. Here are found some of the richest mines in the world. At Anaconda are enormous smelters, while Butte is said to be the greatest mining town in the world.

At Livingstone, 1007 miles from St. Paul, is the point of debarkation for those who wish to visit the wonderful Yellowstone Park. Unfortunately, lack of time denied me this pleasure. From Montana the railroad passes across the narrow strip of Idaho into the State of Washington, which is a country of lofty mountains and fertile valleys. The climate is said to be very equable and the conditions of life exceptionally agreeable. There is a scarcity of water, but irrigation is carried on extensively, and agriculture is a prosperous industry. Mining, milling and fishing are also profitable enterprises of all the States through which I passed.

West of the Mississippi river I was most pleased with Washington. At Spokane, a beautiful and rapidly-growing city, the University of Maryland is well represented. Here former Associate Professor Morris C. Robins has located, and Dr. A. Aldridge Matthews, lately superintendent of the University Hospital, occupies the position of superintendent of St. Luke's Hospital, with a good salary and perquisites of an exceptionally valuable character. Dr. Matthews is one of the surgeons to the hospital, and is becoming well known in his specialty. Miss Burnett, a graduate of our Training School for Nurses, is also superintendent of nurses at St. Luke's Hospital. It was a pleasure in that far-off land to meet former pupils and friends.

A beautiful ride through the Cascade mountains, where the temperature suddenly fell, so that overcoats were agreeable, and we were on the Pacific coast; by Seattle and Tacoma, on Puget sound, southward to the Columbia river, and a few miles farther the thousands of lights of the Lewis and Clark Exposition illuminated the scene, and Portland, Ore., was reached.

One feels lonesome upon arriving at a strange destination, and views with envy those fortunate travelers who are met by friends and relatives with evidences of joy. Whilst in some such frame of mind I passed out of the Union Station, I was surprised at hearing my name called. Dr. Alan W. Smith, who for several years lived in Baltimore, but is now practicing in Portland, recog-

(Continued on page 118.)

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EDITORIAL

CENTENNIAL OF THE UNIVERSITY OF MARYLAND.—Three committees, one representing the Faculty of Physics, one the Alumni Association of the Medical Department, and one the General Alumni Association of the University, have been appointed by these several bodies to formulate plans for the celebration of the centennial anniversary of the University, which will occur in 1907.

It is probable that all three of these committees will come together and present a plan for this celebration which will meet with the approval of the alumni and will be in keeping with the importance of the occasion. It will be the purpose of the BULLETIN to bring to the attention of the alumni the many instructive and important facts connected with the life and work of the University in the past and to show the great value of her service in the cause of education.

Few institutions of learning in America can show as long, unbroken and valuable an educational history as can be presented by the venerable school which the readers of the BULLETIN claim as their Alma Mater. This history, so full of striking incidents, so rich in results and so far-reaching in its influence, is almost unknown to the present generation of graduates. It is quite true that the history of the University has been written by one of her distinguished graduates,* and that the annual catalogue has presented for some years a brief statement of the work of the University, yet it is believed that this historic matter has not had the publicity that it deserves. In this day when history is made so rapidly, and the wheels of progress revolve with lightning speed, we soon lose sight of those striking incidents which make the foundation upon which all important undertakings rest.

That the readers of the BULLETIN may have a general understanding of what the University has done, we propose to publish from time to time the more important facts connected with her life's work, to show the trials and struggles of her beginning and her gradual progress through almost a century of continuous activity and growth.

The Medical Department of the University of Maryland had its origin in the "College of Medicine of Maryland," an institution chartered by the General Assembly of Maryland on the 18th day of December, 1807. It began its first course of lectures with three lecturers, Professors Davidge, Cocke, and Shaw, which were delivered at the homes of these teachers, with a few clinical lectures at the almshouse.

The first class numbered seven, and there were no graduates. Dr. Nathaniel Potter was elected to the professorship of the practice and theory of medicine, and began his lectures with the second session of 1808. Dr. John B. Davidge was elected dean. The first building occupied by the school was located at the southwest corner of Fayette street and McClellan's alley (at this time the corner of Fayette and Hanover streets). This building served the college purposes until the winter of 1812-13.

During the session of 1808-09 the class numbered 10, and the following session the class increased to 18. The first public commencement was held in April, 1810, when degrees were conferred on five graduates.

On December 29, 1812, the General Assembly of Maryland passed an act empowering the Medical College of Maryland to annex to itself three other colleges or faculties, viz., the Faculty of Divinity, the Faculty of Law, and the Faculty of Arts and Sciences, and these four faculties were constituted a university, under the title of the University of Maryland. A number of changes in the faculty were made by deaths, resignations and accessions during the first five years. The need of a college building was greatly felt in the early life of the school, and this need was met by the purchase of the present location of the University at the corner of Lombard and Greene streets in 1812 from Col. John Eager Howard. The present building, modeled after the Pantheon at Rome, was begun May 7, 1812, and so far com-

*Historical Sketch of the University of Maryland School of Medicine (1807-1890), by Eugene F. Cordell, M. D., Class of 1868.

pleted that it was partially tenantable during that session. The money used in the purchase of the ground and in the erection of the buildings was largely raised by lottery, by loans from banks and individuals, and by contributions from public-spirited citizens.

With the erection of the building in 1812, which now stands as a model of classic architecture and an object of pride and inspiration to all of the alumni of the University, the real progress of the University may be said to have had its beginning. Dignity and character were given to the institution by its permanent location in an imposing building, provided with all the accessories required of a medical college of that time.

Subsequent issues of the BULLETIN will contain accounts of the gradual growth of the University from decade to decade and of the many incidents which make her history one of the most instructive and eventful of any educational institution in America.

NOTES AND ITEMS

The alumni of the University for over a quarter of a century back will recall the services of an alumnus who has officiated at every annual meeting of the Alumni Association and who has rendered most valuable services to the University in his zeal for his Alma Mater. The BULLETIN refers to the able and industrious treasurer, Dr. G. Lane Taneyhill. Dr. Taneyhill has without doubt done as much as any single alumnus to keep alive a University spirit and to build up the Alumni Association. He has labored in season and out of season for the good of the Association, and its annual meetings and banquets owe their success to his efforts. He has ever been willing to give his services for the good of the University. Dr. Taneyhill graduated in the class of 1865, and after serving as an assistant surgeon in the Eleventh Maryland Regiment (Federal), at the close of the Civil War he located in this city, where he has since been a most successful general practitioner and influential citizen. Dr. Taneyhill is an ex-president of the Baltimore Medical Association, an ex-school commissioner for the twelfth ward and a member of the Pension Examining Board. From 1882 to 1894 he was recording secretary of the Medical and Chirurgical Faculty of Maryland, and is now a trustee of the Faculty. He has led a most active and useful professional life.

Dr. W. T. Wootton, class of 1899, located at Hot Springs, Ark., in sending his subscription to the BULLETIN, writes as follows: "The BULLETIN is the best yet. We all love the old University and want to keep in touch with it and those now ascending the ladder of fame and usefulness, with whom we sat on hard benches and listened to harder problems being unfolded. May glory and success crown your efforts in giving us that which will keep 'the family' in touch as we labor in different zones."

Dr. Oscar Stansbury, class of 1873, is located at Chico, Cal. Dr. Stansbury enjoys a large and lucrative practice. He is a member of the State Board of Health of California and is emergency surgeon to the S. P. R. R. Co., besides being medical examiner for several insurance companies in his State.

Dr. George W. Dobbin, class of 1894, is professor of obstetrics in the College of Physicians and Surgeons of Baltimore, and one of the most successful and popular obstetricians in this city. With a thorough training and knowledge of his special line of work, he combines a genial and agreeable personality, which assure him a successful future.

Dr. Henry E. Palmer, class of 1892, is practicing with great success and distinction at Tallahassee, Fla. Dr. Palmer is president of the Regular Board of Medical Examiners of the State of Florida. It is with pleasure that we quote a recent letter from the Doctor to the BULLETIN: "Allow me to congratulate you upon the get-up of the BULLETIN. It is newsy, bright and very interesting. Please enter my name on your subscription list." Dr. Palmer evidently appreciates a good thing when he sees it, and we hope that this letter will be an incentive for other alumni who have not subscribed to the BULLETIN to do likewise.

The Hospital staff has been greatly depleted during the past month by absentees on their summer outing. The force on duty has been worked to full capacity, as the Hospital has never had so large a service during the summer months as during the present season. On the medical side there was an average of 30 cases of typhoid fever under treatment during the month of August. Both wards and private rooms have been well filled with patients.

The editors of the BULLETIN have received letters from Drs. Hugh Brent and Ejnar Hansen, written from Denmark, and enclosing a joint paper which appears in the present issue. They write that they have had a most delightful time. They have visited the hospitals of Hamburg, Berlin and Copenhagen, where they were shown the greatest courtesy and given every opportunity to observe the workings and operative technic. Dr. Brent says: "We are both homesick for the University Hospital, and I think by the time we get back we will be willing to accept positions as orderlies, just to be around. After seeing the European difficulties we can more fully appreciate Shipley's troubles and the masterly way in which he has overcome them." They will visit London and Paris before returning home. The BULLETIN is glad to welcome the contribution Drs. Brent and Hansen have sent to it.

With the return of the fall season the work around the Hospital and University buildings assumes a renewed activity. Faces browned by the summer sun give indications of restful outings and of renewed vigor. Greetings, handshakings and recital of individual experiences at the seaside or mountain resort make up the new order of the day as the large working forces of two large institutions again come together to take up the burdens of their respective lines of work. These summer outings, so much more frequent now than in former years, add greatly to the zest and interest of all workers, and, like the Sabbath, should be enforced upon everyone by a social as well as religious sentiment.

Prof. Randolph Winslow, of the chair of surgery, has returned from his trip to Portland, Ore.; Alaska and San Francisco, looking hale and hearty, and greatly improved in health by his long outing and relief from professional work. He gives a most interesting account of his travels. At almost every stopping point he met graduates of the University who are prospering in their Western homes.

Dr. Henry M. Wilson, class of 1850, is one of the oldest of the alumni now living in this city actively engaged in practice. Dr. Wilson has been a most active and useful physician, and is a most highly respected citizen and Christian gentleman. From 1859 to 1873 he was secretary of the Medical and Chirurgical Faculty of Maryland, and was president of the same in 1874-75. He was president of the Alumni Association of the University in 1886-87. Dr. Wilson is distinguished for his skill as a general practitioner and for his great purity and nobility of character. His son, Dr. Luther B. Wilson, a graduate of the University of Maryland, class of 1877, is now a bishop in the Methodist Episcopal Church and a most distinguished clergyman.

Before the October issue of the BULLETIN can make its appearance the regular course of lectures at the University will be in full blast. Old students, with few exceptions, will be back to take up advanced class work, while new beginners—whether Freshmen or more advanced—will have their trials and new experiences. The coming together of large classes of young men is always an occasion for congratulation. At this time of writing the outlook for large classes at the University for next session is most encouraging. The BULLETIN extends a cordial welcome to all who cast their fortunes with the old University.

Dr. Julian F. Chisolm, class of 1900, is a successful specialist in eye, ear and nose diseases, and is located in Savannah, Ga. Dr. Chisolm has recently spent several weeks in Baltimore with Mrs. Chisolm, formerly Miss Mary Levering, of this city.

Dr. E. Rowland Hart, class of 1901, is practicing his profession in Suffolk, Va. Dr. Hart has already built up a fine practice in Suffolk and vicinity, where he is held in the highest esteem. His genial nature and close application to his work have brought him a host of friends.

CORRESPONDENCE

(Continued from page 115.)

nized me, and at once secured rooms for myself and others with whom I was traveling. As the hotels were overfilled, and it was 9 P. M., we were greatly indebted to Dr. Smith for this courtesy. Our long journey of more than 3000 miles was accomplished in great comfort and luxury, though we were 14 hours late, due chiefly to the wreck of a freight train in Idaho. It had taken us five and a-half days to make the trip.

In the next issue of the BULLETIN I will give some account of Portland, the meeting of the American Medical Association, and the fair.

RANDOLPH WINSLOW.

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NEPHRECTOMY FOR RENAL TUBERCULOSIS, WITH A BRIEF REPORT OF THIRTEEN CASES OF NEPHRECTOMY; MORTALITY FOLLOWING OPERATIONS NIL.

BY FRANK MARTIN, M.D.,

Clinical Professor of Surgery, University of Maryland.

(Continued from last issue.)

Case III.—Painful kidney, with malposition and slight hydronephrosis. Operation: Nephrectomy—lumbar route. Cured.

Mrs. J. M. W., aged 59, married, white, female, residing in Philadelphia; was admitted to Hospital November 25, 1898.

Previous History.—Patient has been an invalid for years, complaining of constant dull pain in right side, right inguinal fossa, and extending down right leg; always conscious of a dragging pain in right side of abdomen and right loin, with occasional severe attacks of abdominal pain and pain in lumbar region; attacks at times very severe, lasting for a number of hours and passing off suddenly. Patient, in describing the pain, says: "It feels as if there was something stretching and filling up more and more, until it feels as though it would burst, and after staying at that for some hours would suddenly pass off." She was seen by a number of physicians both in this country and abroad, and about seven years ago the diagnosis of kidney stone was made by Dr. Tyson, of Philadelphia, and an operation for same was resorted to by Dr. W. W. Keen. The kidney was opened, but no stone found. The kidney was noted to be movable, and so a nephrorrhaphy was done. This was not followed by relief except for a short while. Patient states that some pains soon recurred and have been continuing for five years.

Present Illness.—Has continually suffered for the last six months. Attacks of pain have become so frequent, and the paroxysms so severe referable to right kidney, that patient is a total wreck.

Physical Examination.—Tenderness over right kidney in front and behind on pressure.

Urine Report.—This was made by Dr. D. Braden Hyle, of Philadelphia. Urine acid, specific gravity 1020; urea 1.5 per cent., 6.8 grains per pt. oz.; serum albumen a trace; serum globulin a trace; sugar none.

Microscopic Examination.—Many granular leucocytes; granular squamous epithelial cells some, showing beginning fatty metamorphosis, calcium, oxalate crystals, granular, and hyaline casts.

On account of the very frequent and severe paroxysms of pain I advised exposing the kidney and performing a nephrectomy if necessary. An effort was made to catheterize the ureters, but was abandoned.

Operation.—November 27, 1898; chloroform. A long oblique lumbar incision; exposed kidney, and found it lying in a directly transverse position, that is, its long axis was at right angles to the vertical line of the body, with the pelvis up and the external or convex border directed downwards, the superior extremity directed outwards. It was firmly held in this position by adhesions. The pelvis was markedly dilated; the vessels and ureter entered from above. Kidney was removed; no stone was found. On section of the kidney a line of scar tissue was noted running through the cortex to the pelvis, indicating where it had been previously opened, and a cicatrix was found on the convex border, showing point where kidney was sutured. This was firm.

Wound Healing.—Wound healed per primam and patient recovered rapidly, leaving Hospital in less than four weeks after operation, entirely relived from all pain, and expressed herself as well.

Macroscopic Report by Dr. José L. Hirsh.—Right kidney, size normal; capsule not adherent except at convex border at the site of an old scar, which is 2 m. in length; surface smooth, reddish color; cortex normal in appearance; medulla slightly injected; pelvis much dilated, the beginning of ureter admitting the ends of two fingers; mucous membrane of pelvis much injected.

Microscopic Examination.—Hardened specimens show glomeruli normal, interstitial changes

absent. The epithelium of tubules show for most part well-stained nuclei. The excretory tubules are in places slightly dilated, suggesting a beginning hydronephrosis; otherwise normal.

Bacteriological Cultures from Pelvis and Cortex.—Negative.

Diagnosis.—Beginning hydronephrosis.

Note: April 20, 1905.—Patient is perfectly well today, now six years following operation, and has never had any recurrence of pain since the kidney was removed.

Case IV.—Primary unilateral renal tuberculosis. Operation: Nephrotomy, subsequently nephrectomy—lumbar route. Cured.

A. M., aged 26, male, married; occupation, farmer; resided on a farm near Hagerstown. He has always led an outdoor life, and was always strong and robust.

Family History.—Negative.

Previous History.—Had an attack of typhoid fever in 1895, pneumonia in 1901; diseases incident to childhood; suffered no other illnesses. Always regarded himself as perfectly healthy until last part of January, 1897. Was working in the filing-room of a bicycle shop at this time, and was taken with pain in the back, so severe he could not ride his wheel home from work; was away from work four days; passed bloody urine—so much blood that it clotted solid and would not flow; had a little treatment and recovered promptly; urine cleared up in a few days. After this attack enjoyed his usual health; considered himself well until September, 1898. At this time took a bicycling trip to Baltimore and Washington; was away six days, and found while on this trip that he was having positive trouble with his bladder; compelled to stop every two or three hours to empty bladder. This was unusual; he could previously pass a whole day without voiding urine. Did not notice that he passed any blood at this time. After this trip he was about his usual labors on the farm, cutting corn, etc. Latter part of October and November his bladder gave him considerable trouble, having to void the urine every couple of hours, having to rise three or four times at night; passed no blood, but noticed a whitish sediment from the night passages. His physician called it cystitis. He was under the care of a physician until latter part of 1898, being confined to the house; no blood noted in the urine. About April 1, 1899, began to get out of doors and do some light work on the farm; bladder about as it had been all winter; suffered considerably at this time. Latter part of July began to have fever and chills and sweats during the night; pain in the loin on the left side; sleep much disturbed by the necessity of emptying bladder. Came under Dr. Reichard's care August 28, 1899. An amount of urine was voided in 24 hours, about three pints; large quantity of sediment, which stuck to vessel when contents emptied. Microscopic examination (as made by Dr. Reichard) shows pus and squamous epithelium; three-glass test shows pus in all glasses, but largest amount in third; temperature ranged from 97 to 102; every few days would have a chill, followed by a high temperature, 104¼°, followed by profuse and exhaustive sweats; appetite capricious; attempt to pass catheter gave intense pain; showed the presence of functional spasmodic stricture; renal palpation showed an enlarged and painful mass over left kidney. Entered University of Maryland September 3, 1899, with diagnosis of pyonephrosis.

Examination.—For past five weeks patient has suffered with pain in left side; has emaciated considerably; previous weight 137; weight now 118 pounds. Renal palpation shows enlargement filling the left side of his abdomen, which is tender on pressure. Nothing observed in the region of the right kidney.

Examination of Urine. — Micturition painful and frequent—25 to 40 times in 24 hours; amount in that time 850 c. c.; amount of urea 12 6-10 grams; acid, specific gravity 1020; abundance of albumen; sediment of pus and epithelium cells in large amount.

Blood Examination.—Hemoglobin 58 per cent.; leucocytosis 12,280.

Operation.—Under ether, September 6, 1899; nephrotomy. Kidney opened and drained; large abscess evacuated from the kidney and sections of kidney removed for examination.

After a few weeks' stay in the Hospital he returned home. His wound kept tucked with gauze and draining.

Microscopic Report. — Section of kidney removed showed tuberculosis; pus sterile.

After patient improved in his general condition he returned to the Hospital on October 26, 1899, and a nephrectomy was done on October 27, 1899. Under ether a large lumbar incision was made. The kidney was found markedly adherent, of very large size, and after a tedious, difficult dissection it was dissected out and removed. Some inches of the ureter were removed with it, because the

tubercular process had extended into the ureter, going fully three inches down the ureter towards the bladder. This was taken away with the kidney. Patient made a good recovery and left the Hospital in four weeks' time.

Note: This patient remains well and has no trouble whatever, and no further evidence of any tuberculosis. The vesical irritation which was complained of, and which caused such frequent and painful micturition, continued for awhile after the operation, but ultimately cleared up and disappeared.

I failed to state in this case that an examination of the sediment in the urine showed tuberculous bacilli, and inoculation experiments upon guinea-pigs developed tuberculosis in them.

Case V.—Unilateral cyst of kidney, the cyst being due to an endothelioma of the adrenal gland. Operation: Nephrectomy—transperitoneal method. Cured.

Mr. E. W., aged 48; was referred to me by the courtesy of Dr. William Crawford Johnson, of Frederick, Md., for the relief of a large movable mass in the left abdomen. Patient was admitted to University Hospital June 26, 1900.

Family History.—Negative.

Previous History. — Nothing in the previous history of moment or having to do with the present illness. Has been generally healthy, apart from an attack of scarlet fever, which left him with deafness. He gives no history of any disease of moment.

Present History.—Present illness began about eight months ago, with pain in left side of abdomen, which continued at intervals for several months. About six months ago noticed a lump in left side of abdomen between border of last rib and ilium about the size of two fists; no pain on pressure.

Physical Examination.—Patient tall, slender; height 5 feet 10½ inches; weight 145 pounds; lungs and heart normal; abdomen soft; right kidney not palpable nor tender; a large movable mass, size of a small cocoanut, found in the left side of abdomen; has a cystic feel to the touch and can be moved up in the direction of the left kidney; not painful on pressure; no vesical symptoms; no increase of frequency of urination.

Examination of Urine. — Negative; specific gravity 1022; acid; no sugar; no albumen; no casts; amount in 24 hours 1200 c. c.

Blood Examination.—Leucocytosis 73,000; red cells 5,100,000; hemoglobin 75 per cent.; stained specimen of red corpuscles regular in shape; no signs of any degenerative changes.

Operation.—Ether; nephrectomy—intraperitoneal or transperitoneal route; abdomen opened by incision made through the outer border of the left rectus sheath; length of incision 14 cm.; colon and omentum pulled upwards and tucked into upper abdomen with gauze and the mass uncovered; it proved to be a large cyst of the kidney; abdomen systematically explored by gloved hand, but nothing further abnormal noted; right kidney to the touch and inspection proved to be of normal size and in proper position; no cyst to be felt or seen in it anywhere; peritoneum over cyst was opened; large blood vessels over mass were tied; kidney dissected up and removed by tying off ureter and vessels separately; toilet of the abdomen was made and the abdomen closed without drainage. A small opening was made through the loin on that side and a small wick of gauze passed into the space from which the kidney had been removed. Patient made an uninterrupted recovery.

Gross Description of Specimen.—Tumor consisted of a soft mass, about the size of a large orange, situated on the upper surface of the kidney. It was enclosed within a firm, fibrous capsule and fitted into a cup-shaped depression on the upper surface of the kidney. The kidney tissue was not invaded by the tumor, but was completely separated from it by the fibrous capsule mentioned above.

The microscopic report as given me by Dr. Wm. R. Stokes, who kindly made the examination of specimen, is as follows:

"On section the tissue of this new growth was brownish-red, and very soft and hyperemic. The line of demarcation between the kidney substance and the tumor was very clearly seen, and it seems probable that the new growth has developed directly from the tissue of the adrenal gland, replacing the normal tissue of this organ with tumor tissue. It has not invaded the substance of the kidney as a secondary metastatic growth, and with the exception of the evidence of compression in the upper portion of the kidney the organ seems normal.

"Microscopic Examination of Specimen.—Under the microscope the tumor consists of double rows of ovoid or cuboidal cells, with round or oval nuclei, surrounded by a moderate amount of protoplasm. This protoplasm often contains fine or coarse granules of dark-brown pigment or clear

vacuoles resembling fat drops. These rows of cells are arranged in an irregular series of convoluted curves, at times being so doubled up and twisted in and out as to resemble the ramifications of a papilloma. These are always seen to surround large open spaces filled with red-blood corpuscles. Sometimes a cross-section of one of these spaces resembles a dilated capillary surrounded by a series of cells several layers deep, forming a tuft-like projection from the periphery of the central lumen.

"The tumor in places has apparently undergone degeneration, and the cells are shrunken and their nuclei are small, poorly stained, or absent. These areas contain small collections of polymorphonuclear leucocytes. The tumor contains a very fine reticulum of connective tissue. It gives the general appearance of an endothelioma, which probably originated from the capillary plexus of the adrenal gland.

"Sections through the junction of the kidney and the tumor showed a thick fibrous capsule separating one from the other.

"This capsule contains many flattened and atrophied glomeruli and tubules, which, as they approach the tumor, become separated by masses of connective tissue. A few greatly-compressed tubules with very flat cells can be made out just at the junction of tumor and kidney tissue, and the capsule of the kidney is not thickened. The compression of the glomeruli and tubules becomes less evident and gradually disappears as the distance increases from the junction of the tumor and kidney. Sections from other portions of the kidney show nothing abnormal.

"These tumors of the adrenal gland have been described by a number of observers and have been given various names. The majority of writers consider them endotheliomata. They often invade the kidney substance, at times apparently beginning to develop within the tissue itself, as though growing from some aberrant portion of the adrenal gland within the substance of the kidney.

"These adrenal endotheliomata also form metastases, secondary growths having been found in the inferior vena cava, the retroperitoneal glands, the lungs, the pleura, and the glands of the neck.

"Cullen, in the *Bulletin* of the Johns Hopkins Hospital for March, 1895, described a tumor very similar to the present case. This was removed by Dr. Kelly by a lumbar incision, and was found to be a tumor of the upper half of the right kidney. This growth had a capsule directly continuous with that of the kidney, showing that it developed within the substance of the organ. A tongue-like process of this tumor projected into a pyramid of the kidney and the pelvis, showing invasion of this viscus. Like our present case, the tumor substance was soft and in places necrotic. The microscopic examination showed the same double layers of cuboidal cells surrounding blood spaces, and Cullen concluded that it had orginated from a portion of the adrenal gland which had been included within the kidney substance."

Case VI.—Unilateral large cystic kidney, left kidney structure having been entirely replaced by the cyst. Operation: Nephrectomy—transperitoneal method. Cured.

Miss F. A., aged 62, white; referred to me by Dr. W. Crawford Johnson, of Frederick, Md. Entered Hospital July 5, 1900.

Family History.—Negative.

Previous History.—Negative; has always been robust and strong, and, apart from present trouble, has enjoyed good health.

Present History.—Present illness dates back 11 years, when she began to have pain of severe nature in left side, in left lumbar region. Local and constitutional treatment were resorted to without relief. The pain in her side slowly but continuously increased in severity for five years. At times these paroxysms of pain would be very intense and violent. Six years ago, after having had one of these violent attacks of pain in the abdomen, she came to Baltimore and consulted Dr. L. McLane Tiffany, who found upon examination an enlargement of the left side of abdomen. Operation was determined upon and things arranged for operative interference. Upon a second examination, however, on the morning set for operation, the above enlargement previously noted had disappeared, so operation was abandoned and patient returned home. In the interim she had a number of similar attacks of violent pain, after which a fullness would again be noted in the left lumbar region, and again disappear. She had two very severe attacks—one two years ago and one one year ago, followed by enlargement, which did not disappear. Patient states that she has noticed for quite a long time this enlargement in left side. Last fall a year ago she called her physician's attention to it, but no examination was made. April, 1900, her physician made an examination and found (quoting from his letter) "a tumor in the left side of the abdomen between the umbilicus and the crest of the ilium as large as a cocoanut,

of that shape, with a soft, doughy feel. At no time has there been any soreness, pain on handling or fever; has steadily increased in size since last fall."

Physical Examination.—Nothing noted of any moment referable to any other part of the body save in the abdomen. This was noted to be soft, relaxed and to have very thin walls, and palpation revealed a well-defined movable mass, not painful on pressure, filling the left abdomen, and the mass could be pushed up slightly under the ribs on the left side. It was about the size of a child's head and to my touch unmistakably cystic. No history of vesical symptoms; no difficulty in voiding urine; no frequency in or painful urination; no pain on pressure over bladder; never noted blood in urine; pushed up into the region of the kidney; nothing abnormal noted in the region of the right kidney; temperature and pulse normal.

Examination of Urine.—Negative; acid, specific gravity 1020; no albumen; no sugar; epithelium urates and a few hyaline casts; on entrance amount of urine in 24 hours scant, 650 c. c.; skin was acting profusely, as it was an exceedingly hot day.

Blood Examination.—Negative; leucocyte count 9240.

Diagnosis.—I gave as my opinion that the probabilities were that we had to do with a unilateral cystic kidney, and advised its removal. Catheterization of the ureters not attempted.

Operation.—July 9, 1900; chloroform; nephrectomy by the transperitoneal or intra-abdominal method. The abdomen was opened through the left rectus sheath; the incision was made purposely long in order to give sufficient room to work. After the abdomen was opened the following notes were recorded at the time of operation: A large mass noted, extending from the ribs to the lower abdomen to within four fingers' breadth of symphasis; stomach was on a level with the umbilicus and covered with the gastro-colic omentum and colon; the tumor, upon pulling the omentum up, together with the omentum and stomach, a large mass was revealed, covered by the posterior parietal peritoneum, with very large veins the size of one's finger coursing over it, the mass large-sized, and to the feel cystic retracting up the thoracic wall the interior surface of the liver is noted normal in size and appearance; on retracting left abdominal wall and thoracic wall, spleen is seen and observed to be very small in size. I now passed my gloved hand over to the right side of the abdomen and examined right kidney. It is of normal size. Nothing abnormal could be noted, and upon exposing it to view no cysts were seen; large veins coursing over cyst were ligated off and divided; posterior parietal layer of peritoneum divided in the direction of the abdominal incision and dissected free on both sides; many large-sized vessels were clamped during the dissection. The stripping from the peritoneum and enucleating it from the perirenal tissue was done carefully, but slowly, for fear of rupturing the cyst, which is quite thin. None of the kidney structure is left, having been all replaced or taken up by the cyst, as can be seen by the accompanying photograph. The kidney is so distended and distorted into one large cyst that the hilum cannot be made out, and the anatomical relation normally present between the ureter, pelvis of the kidney, and the renal vessels did not exist. With some difficulty the kidney was finally dissected out, and the ureter found and tied off; so likewise were the vessels and the mass leveled. It proved to be a large cystic kidney. The toilet was now made, and the posterior parietal layer of peritoneum was brought together by a continuous fine silk suture, shutting off the abdominal cavity from the cavity formed by the removal of the kidney. No hemorrhage at any time during the operation, the vessels being clamped before their division, and the oozing areas from the perirenal space controlled by gauze packing, which, when removed, left surface dry. The abdomen was closed without drainage and the patient stood operation well; no shock; reacted nicely; no vomiting; amount of urine passed in 24 hours per catheter 450 c. c.; urea 13 3-10 grams. Made an uninterrupted recovery and wound healed per primam under one dressing. Patient left Hospital at the end of the fourth week.

Case VII.—Painful kidney, right. No relief had been obtained from a nephrorrhaphy. Present operation: Nephrectomy; character of anesthetic, subarachnoid cocainization. Cured.

Mrs. J. C. C., aged 50; referred to me by Dr. Charles W. Wainwright, of Princess Anne.

Family History.—Negative.

Previous History.—Negative, except that about a year ago a nephrorrhaphy was done for a movable kidney, followed by only slight and temporary relief.

Present History.—Patient returned to University Hospital; and stated that she suffered severe attacks of pain referable to the kidney, which had been growing worse, until now they had become

almost constant. Her general health was much undermined from the constant pain which she had suffered, and examination revealed the organ not displaced, but it was thought best, under the circumstances, to take the organ away, due to the severe and continuous suffering. She was both unable and unwilling to take a general anæsthetic, and as spinal-cord cocainization had just come into use, it was suggested to her, and she acquiesced, and said she would have it used upon her. It had never been used in Baltimore before, so it was undertaken with a certain amount of concern and apprehension.

Operation.—December 6, 1900; subarachnoid cocainization. Twenty minims of a 2 per cent. solution of sterile cocaine were injected into her subarachnoid space between the fourth and fifth lumbar vertebrae, and anæsthesia was so complete that the kidney was removed by the lumbar route apparently without the patient suffering pain. If she had pain, she in no way intimated it. There was no difficulty in the operation whatever. Petit's triangle was opened and kidney removed without slightest difficulty; wound closed without drainage.

Subsequent History. — There was nothing of note in subsequent history. From a surgical standpoint she did perfectly well. The only thing worthy of note is that she suffered, as all these cases of subarachnoid anæsthetics do, from severe headache, which kept up for 36 hours. She made an excellent recovery and left the Hospital much relieved. A few years afterwards she had abdominal trouble in the form of a pelvic mass, and she returned to my service at the Hospital and had her abdomen opened for the relief of this pelvic trouble, and again insisted on the use of the subarachnoid cocainization. Again it was tried and proved very efficacious. Patient went through with a laparotomy in a most satisfactory way; no expression of pain from her whatever.

Case VIII.—Ureter of left kidney cut by an operator who was performing an operation for the removal of a pelvic mass. Operation: Nephrectomy done to relieve the aforesaid condition. Cured.

Mrs. L., aged 33.

Family History.—Negative.

Previous History.—Negative.

Present History.—Was operated upon at St. Joseph's Hospital, some 10 days or two weeks prior to my being called to see the case, for the removal of some pelvic mass, probably malignant, and the operator, in attempting to get the mass away, cut the ureter. It was noted from the discharge through the vagina, as there had been a vaginal drainage used in the case, that urine was coming freely on that side, and as the mass in the left side had invaded the tissues and possibly the ureter to such an extent that an attempt to reunite the ureter was thought inadvisable, so I was asked to remove the kidney.

Operation.—July 2, 1901; ether. By the lumbar route I did a nephrectomy. No difficulty was experienced; kidney was simply dissected up and the vessels tied off; wound closed without drainage. Patient made an uninterrupted recovery so far as the removal of the kidney was concerned, but I am told that the malignant trouble returned in the course of a year or 18 months and caused her death.

[CONTINUED IN NEXT ISSUE.]

REPORT OF A CASE OF TUBERCULAR PACHYMENINGITIS OF THE SPINAL CORD.

By Irving J. Spear, M.D.,

Instructor in Psychiatry, University of Maryland.

The following is the report of a case occurring in the service of Dr. Atkinson: On June 4 I was asked to see a patient in the colored male ward of the University Hospital. The patient entered the Hospital two days previously, complaining of complete retention of urine and pain in the back.

Family history was negative.

Past history was of no importance, with the exception that he had had syphilis about 17 years ago.

Present Illness.—For about six or seven months the patient has been complaining of pain in the back, neck, shoulders, and arms. These pains are gradually increasing in severity, and are increased on movement. For the past four weeks he has been unable to work on account of weakness and pain. Was unable to pass his urine, and was, therefore, brought to the Hospital. For the past two days while in the Hospital he has been catheterized regularly.

Physical Examination. — Well-developed colored male, aged 37; expression anxious; intelligence fair; skin normal; mucous membranes of good color; nose, eyes, ears, and mouth appear well formed.

Lungs.—On examination give evidence of considerable hypostatic congestion and edema.

Heart. — Slight accentuation of second aortic and pulmonic. Pulse about 88, regular and of good volume; arteries show fibroid changes.

Abdominal organs are apparently normal. Genitals: Presence of large chancroidal sore covering nearly the entire dorsal surface of the penis. Marked phimosis; slight urethral discharge.

Examination of Nervous System, June 4.—Intelligence somewhat obtunded; speech clear; expression anxious. Motor functions: Muscular system well developed; no atrophies or abnormal movements.

Lower Extremities. — Patient able to slightly flex and extend the toes. Absolute paralysis of the leg and thigh. Trunk: Paralysis of abdominal muscles; abdomen distended and intestines full of gas; paralysis of intercostal muscles; breathing is diaphragmatic, upper portion of thorax being somewhat movable, due to the action of the accessory muscles of respiration.

Upper Extremities.—Slight motion of the flexors and extensors of the fingers and wrist joint; more power in the muscles of the arms and shoulders; weakness more marked on the right side; muscles of the neck and face are fairly strong. It is not possible to test co-ordination on account of extreme muscular weakness.

Reflexes.—Deep; both knee reflexes slightly exaggerated; tendon Achilles present.

Upper Extremities. — Reflexes about normal; superficial reflexes are all lost; Babinski is negative; Kernig's sign negative. Rectal reflex: Complete retention of fæces. Vesical reflex: Complete retention of urine.

Sensory Function. — Marked obtunding and confusion of the sense of heat, cold, and pain. This is less marked of tactile and muscular sense. This obtunding and confusion is very extensive, involving the entire lower extremities, the trunk, hands, and lower part of forearm, but is not present over the arms, shoulders, and face, where sensation is about normal in all its qualities. At time of examination there were no paræsthesias. Tenderness and pain were marked along the entire spinal column, over the back and shoulders, radiating down the arms, worse on the right side; particularly there was a tingling pain from the elbows down to the hands. Cranial nerves were normal. A diagnosis was made of pressure on the spinal cord, located posteriorly at about the third or fourth cervical segment. The patient died June 5 from respiratory failure. The heart continued to beat after complete cessation of respiration.

Autopsy was performed on June 6 by Professor Hirsh. The spinal cord and brain were removed. The following is a brief abstract of the autopsy:

Autopsy 26 hours after death; well-developed colored man, with good muscular and skeletal development; abdominal cavity contains small amount of blood-stained fluid; left pleural cavity contains 500 c. c. of blood-stained fluid; right pleural cavity free from fluid, but contains extensive adhesions; heart shows nothing abnormal; upper lobe of right lung shows some old caseated tubercles and one small cavity; abdominal viscera normal.

Brain somewhat softened from post-mortem change, but shows nothing abnormal. In the cervical region of the cord corresponding to the third or fourth cervical vertebra the meninges are very much thickened, especially posteriorly, giving the cord a rather spindle-shaped appearance in this region. This thickened area has a rather gelatinous appearance, with numerous punctate hemorrhages.

Anatomical Diagnosis.—Fibrinous pleurisy on both sides, with effusion into left cavity; pachymeningitis of the cervical region of the cord. Microscopical examination of the cord, corresponding to the third and fourth cervical segments, shows the meninges to be very much thickened, about four times normal size. Thickening extends completely through the dura, and to some extent involves the pia. There are many tubercles scattered throughout this area, some of them well formed, showing typical giant cells, epithelioid cells, and leucocytes. There are likewise areas of caseation. The process is limited to the meninges, and shows no involvement of the cord whatsoever. Some of the blood-vessels slightly enlarged; a few areas of hemorrhage are observed.

Diagnosis.—Tubercular pachymeningitis of the third and fourth cervical segments of the cord.

Dr. Louis A. Weigel, class of 1875, celebrated skiagrapher of Rochester, N. Y., who suffered serious injury from too zealous attention to his X-ray works, is again enjoying good health. Owing to awful burns incurred by his constant presence while the apparatus was in action his right hand had to be amputated at the wrist, and all of his left suffered a like fate, save the thumb and little finger.

CORRESPONDENCE.

To the University Bulletin.

Portland, the metropolis of Oregon, is situated on both sides of the Williamette river, about ten miles from its confluence with the Columbia river, and about 100 miles from the coast. It is an attractive city of 125,000 or possibly 140,000 people, though the last census placed its population at about 90,000. In common with the other cities of the Western coast it is growing rapidly. In the central portions of the town we find large and handsome business houses and closely built streets, but in the residential portion the houses are on the cottage style, with yards and gardens. The houses are built chiefly of wood, and have a profusion of flowers growing around and upon them, and giving to the city a most charming appearance.

The Japanese current, similar to the Gulf stream in the Atlantic ocean, bathes the western shores of our country and tempers the climate to such an extent that the extremes of heat and cold experienced by us are unknown there. Flowers bloom the year round at Portland, and owing to this fact the sobriquet of "The Rose City" has been applied to the place.

The city lies mostly in a flat plain, surrounded by high hills, from which beautiful vistas of river and mountains and country are enjoyed. The hotels were overcrowded during my visit, and it was difficult to get suitable accommodations, and I was indeed fortunate in meeting an acquaintance as soon as I arrived, who secured satisfactory lodgings for me, whilst restaurants were to be found everywhere. Of course the city was full of strangers, attracted by the fair, as well as by the various conventions meeting there this year.

In comparison with the Chicago and St. Louis fairs, the Lewis & Clark Exposition is of small importance. It is, however, beautifully located, with an especially fine electrical illumination and handsome buildings. The Western States are well represented, having characteristic State buildings; but only New York and Massachusetts from the East seemed to have erected State edifices. The forestry exhibit was very instructive, as was the display of the United States Government.

The other features of the fair were chiefly those of a bazaar, the Japanese especially having large stocks of goods for sale. In one of the buildings is to be seen the log shack in which President Roosevelt lived whilst ranching in Dakota. The American Inn, a large, but temporary structure, is within the fair grounds, and some of the entertainments given to the American Medical Association were held in this hostelry.

The general meetings of the Association were held in the armory of the Oregon National Guard, the acoustic properties of which were so miserable that it was difficult to understand the speakers, whilst the various sections met in churches and schools in the neighborhood. Notwithstanding the distance of the place of meeting from the greater part of the country, a large number of physicians were in attendance, and the interest in the work of the sections was well sustained. About a dozen medical men from Maryland found their way to the meeting, though a number who were on the programme failed to put in an appearance. Of course, my interest centered in the work of the surgical section, of which Maurice H. Richardson, of Boston, was chairman, and Floyd W. McRae, of Atlanta, secretary.

Papers were read upon a variety of subjects, and some interesting cases were exhibited. The subject of appendicitis was prohibited, and we were spared the acrimonious discussion which usually occurs at these meetings. Gastric and duodenal ulcer was presented by several writers, the plea being urged that most cases of protracted digestive disorder is due to this cause and requires surgical rather than medical treatment. An important paper was read by Dr. A. D. Bevan, of Chicago, on "Acid intoxication and late poisonous effects of anæsthetics. In this paper he showed that acute toxic symptoms occasionally occur several days after the administration of anæsthetics, especially chloroform, from which the patient generally dies. The symptom complex is quite constant, consisting of fever, rapid pulse, fright, incoherent speech, and ultimately coma and death. The condition is an hepatic toxemia, and is due to acute fatty degeneration of the liver. Gall stone and liver surgery received a due share of attention, but nothing especially new was advanced, except greater boldness in attacking the liver substance, removing growths and repairing clefts and incisions at once by sutures. The most interesting surgical work reported was a case of complete laryngectomy, trachectomy and œsophagectomy for can-

cer, by Dr. Wallace L. Terry, of San Francisco. Several years previously he had removed the larynx with an excellent result, the patient being able to talk by means of an artificial apparatus. The growth recurred, involving the trachea and œsophagus, which were removed to the level of the sternum, leaving a gutter in the neck, from the base of the tongue to the supersternal notch. The patient was in excellent health, earned a livelihood for his family, but could no longer speak. He was able to swallow by means of a funnel and tube, which fitted into the œsophageal opening and was suspended under the base of the tongue, so that liquid food could pass from the mouth down through the tubes into the stomach. There was slight leakage, but not to any great extent. The patient was exhibited, and drank milk before the audience. "Perforation in Typhoid Fever," by Dr. Richard H. Harte, of Philadelphia, and "Penetrating Wounds of the Abdomen," by myself, were the titles of papers read. Two papers on tuberculosis of the kidney were on the programme, showing the interest this subject is arousing at this time. Dr. Willis, of Seattle, exhibited a number of cases of congenital hip dislocation, in which good results had been secured by repeated gentle manipulation, rather than by the forcible reduction of Lorenz. In the discussion that followed, my friend Lorenz, in the language of the day, "got it in the neck."

The profession of Portland made every effort to entertain the visiting doctors and ladies, and many handsome receptions were given at the homes of the local physicians. A steamboat excursion up the Columbia river was given on the last day of the session, and what might be called a "salmon bake" was enjoyed by many. Three steamboats conveyed us about forty miles up the beautiful river to Bonneville, where the outdoor entertainment was partaken of. The steamboats on the Columbia river are mostly of the stern-wheel variety, and use coal oil for fuel. The river is associated in our minds with salmon, and it was interesting to see the large wheels, propelled by the swift current, which in an automatic manner, scooped the fish up and dropped them in the tanks.

An incident of great personal interest and gratification to me occurred when I had finished reading my paper. As I took my seat two gentlemen at once came to speak to me. One was my classmate, Dr. Oscar Stansbury, whom I had not seen for nineteen years, and did not know whether he still lived. He is a prominent and prosperous physician residing at Chico, California, and I am sure the meeting in this unexpected manner was mutually enjoyable. I was, unfortunately, unable to accept his pressing invitation to visit him at his home. The other gentleman was Dr. Otto S. Binswanger, of the class of 1882, who has been living at Portland since he graduated, and has been for many years professor of chemistry in the medical department of the University of Oregon. I had lost track of him and was greatly pleased to see him and to learn that good fortune had followed him in his distant home. Two gentlemen with whom I was closely associated during my sojourn in Vienna in 1883 also were in attendance at the convention, and with whom I renewed a pleasant acquaintance: Dr. W. P. Manton, of Detroit, Mich., and Dr. Walker Schell, of Terre Haute, Ind. In these days of rapid transit this world is indeed small.

I believe I mentioned in my previous letter the presence of former superintendent of the University Hospital, Dr. A. Aldridge Matthews, and former Associate Professor, Morris C. Robins, who are now located at the prosperous city of Spokane. It was certainly a great pleasure to me to see them again and to hear them speak in an enthusiastic manner of their Western home.

RANDOLPH WINSLOW.

Dr. James Love, class of 1897, a former resident physician in the Lying-In Hospital of the University, but now practicing his profession at Jacksonville, Fla., is spending a few days of his two weeks' vacation in Baltimore. On his way North he visited Fairfield, N. C. Before starting homeward he expects to run over to New York. Dr. Love never misses when in Baltimore a visit to the Hospital, in whose work and advancement he takes a great pride and interest. Associated with him in practice is Dr. Maginniss, also of the class of '97. We are glad to hear these two alumni have built up a lucrative practice. Other representatives of our school in Jacksonville are Drs. Holloway and Terry, both of the class of 1903.

Dr. E. Hall Richardson, class of 1891, of Farmville, Va., was married June 17 to Miss Emily Gould, of Mt. Washington, Md.

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EDITORIAL

THE FIRST FACULTIES OF THE UNIVERSITY OF MARYLAND.—

The act of the General Assembly of Maryland founding the Medical College of Maryland, provided that "until further arrangements be made by the regents of the said College, John B. Davidge, M. D., and James Cocke, M. D., shall be joint professors of anatomy, surgery, and physiology; George Brown, M. D., shall be professor of the practice of and theory of medicine; John Shaw, M. D., shall be professor of chemistry; Thos. E. Bond, M. D., shall be professor of materia medica, and William Donaldson, M. D., shall be professor of the institutes of medicine." Dr. Brown and Dr. Donaldson declined to accept the chairs assigned to them. Dr. Nathaniel Potter was elected to the chair of practice and theory of medicine, but did not commence the course until the second session (December, 1808). Dr. Bond was forced to resign on account of ill health. The work of instruction then devolved on Drs. Davidge, Cocke and Shaw. Dr. Shaw died January 10, 1809, from consumption contracted in the lecture room. The vacancies in the chairs of chemistry and materia medica were filled in 1809 by the appointments of Drs. Elisha De Butts and Samuel Baker. In 1812 Dr. Wm. Gibson was elected to the chair of surgery, and Dr. Richard Wilmot Hall was made adjunct professor of obstetrics, to which was added diseases of women and children. During the session of 1813-14 Dr. Cocke died, and Dr. Davidge succeeded to the chair of anatomy. During the session of 1814-15 Dr. Maxwell McDowell was elected to the vacant chair of institutes of medicine. Drs. James Bain (class of 1816), Dr. John Buckler (class of 1817), and Dr. John D. Godman (class of 1818,) held positions as lecturers on anatomy and probably served as prosectors. Dr. Wm. Howard was adjunct professor of anatomy under Dr. Davidge in 1820. Dr. Duncan Turnbull was the first demonstrator in 1821.

During the winter of 1817-18 Dr. Davidge sustained a fracture of the thigh bone and was unable to lecture. John Godman, his assistant, an undergraduate, was called upon to take his place, and in this manner laid the foundation for that distinguished position he subsequently reached as a teacher and scientist.

In 1819 Prof. Gibson resigned the chair of surgery to accept the same chair in the University of Pennsylvania and his position was filled by the election of Granville Sharp Pattison, a brilliant, but erratic, Scotchman, who infused a new vigor into the University and established the anatomical and pathological museum familiar to many of the alumni. Dr. Pattison severed his connection with the University in 1826, and Dr. Davidge assumed charge of the chairs of anatomy and surgery, with Dr. John Buckler as adjunct professor of anatomy. Dr. Davidge was forced to resign his connection with the University in 1827 on account of infirm health and Dr. Nathan Smith, professor of anatomy in Jefferson Medical College, Philadelphia, was elected professor of surgery. Dr. Smith brought great eclat and vigor to the University and dominated its policy until his retirement in 1870. In 1829 Dr. John D. Wells, of Boston, was elected professor of anatomy, but he died on July 25, 1830, with pulmonary consumption. Dr. Benjamin Lincoln, of Vermont, filled the chair of anatomy, made vacant by the death of Dr. Wells, holding an appointment as lecturer until the spring of 1831, when he returned to his home in Vermont. Dr. Thomas H. Wright, of Baltimore, was then elected to the chair of anatomy, but resigned before lectures begun. Dr. Eli Geddings, of South Carolina, was next elected to the chair of anatomy and physiology, which he filled until 1837. On April 3, 1831, Dr. Elisha De Butts died, after having held the chair of chemistry from 1809. He was succeeded by Professor Ducatel, who filled it until 1837 when he resigned. In 1833 Prof. Samuel Baker and Prof. Maxwell McDowell resigned from the faculty, the former after twenty-four years and the latter after nineteen years of service. Prof. Robley Dunglison, of the University of Virginia, was elected as suc-

cessor to Prof. Baker, but resigned in 1836 to become professor of institutes in Jefferson Medical College, Philadelphia. Dr. R. E. Griffith, of Philadelphia, held the position vacated by Dr. Dunglison for one year. Dr. Henry W. Baxley was elected to the chair of anatomy after the resignation of Dr. Geddings in 1837. The entrance of Dr. Baxley into the faculty was the occasion for dissensions, which practically resulted in disruption. Resignations were of frequent occurrence and there were two faculties, one representing the trustees, and the other the regents, each conducting courses of instruction and holding commencements. The affairs of the University had now reached a critical stage. The BULLETIN will show in subsequent issues the outcome of these disturbances and the new era of prosperity which came to the institution after the regents were reinstalled in its management.

THE LARGER UNIVERSITY OF MARYLAND.—For sometime back the question of reorganizing the department of arts and sciences and of enlarging the scope of work in connection with the University of Maryland in order that it may more fully perform the functions of a State University, has been agitated by some of the friends and alumni of the institution. This discussion has assumed a practical form, and a meeting of representatives of the University, St. John's College and the Maryland Agricultural College was recently held at the Governor's office, in this city, for the purpose of formulating plans looking to the consolidation of these schools. Resolutions favoring a consolidation of these different institutions into a State University were adopted and a sub-committee was appointed to draw up a plan of organization that might lead to the results desired by the respective interests represented by these schools. The report of this committee will be anxiously awaited. It is not believed that a radical change in the organization of the present institutions is possible or desirable at this time, but it is believed that a closer relation can be established between these different schools and that a State University, in fact as in name, will be the ultimate result of a temporary merger of the individual interests now in control of the several departments of the University and of St. John's College and of the Maryland Agricultural College. A radical change in the government of these different interests by way of consolidation of property interests and release of control of individual management is not possible under present conditions, but it is possible to bring the individual units, by gradual steps, under a single managing body which could direct the affairs of the larger university to better advantage than under the present management.

A union of St. John's College and of the Maryland Agricultural College with the medical, law, dental and pharmaceutical departments of the University of Maryland is perfectly feasible without a sacrifice of their present government or surrender of their charter privileges. The consolidation can be made as a temporary experiment by an assumption of the title "The Department of The University of Maryland," and by an agreement to affiliate upon terms that will be mutually advantageous. As time suggests the advantages of closer union or of a stronger organization it will be possible to adjust individual interests to meet the demands of the larger University.

Under present conditions it would not be possible for the medical department of the University, which is the oldest and largest of the departments, to assent to any change in its government that would impair its financial obligations. This department has made itself responsible for a large indebtedness, for which its tuition fees are pledged. It is in duty bound to meet its business obligations, for which no other department is responsible. The faculty of physic realizes the advantages which might come to the University by a consolidation with the institutions named, and is not unfriendly to a union which does not place the burden of its support upon the medical department. It will meet this reorganization movement in a friendly spirit and will co-operate with those who have it under consideration.

CLASS REUNIONS OF THE ALUMNI OF THE UNIVERSITY.

A movement is being considered by members of the class of 1881 to hold a reunion of the surviving members of this class on the occasion of the 25th anniversary of graduation, which will occur next year. The BULLETIN would urge that this movement is a most important one and that it should be made a success. Nothing will contribute more to the pleasure of old classmates than a meeting of this character after a quarter of a century of professional work in

widely scattered fields of labor, and nothing will do so much for the good of the old University as the coming together every year of the surviving members of classes as they reach the quarter-century mile-post. As far as we know, the first class of the University to celebrate the 25th anniversary of graduation was the class of 1876, which held a reunion at the Hotel Rennert, in this city, in 1901. At this meeting a large number of the surviving members were present and the occasion was a most enjoyable one. The BULLETIN was not in publication at that time to give a record of that meeting, but the writer of this notice was present and he recalls the pleasure of that occasion as one of the most enjoyable experiences of his professional life. As old friends gathered together for the first time since graduation and related the experiences of a quarter of a century of professional life or recalled the memories of student days the hours passed rapidly by, whilst friendships were again cemented for coming duties and interests in life's great work. When the roll call announced the absent companions of former days and absentees were accounted for, it was noted how some had crossed over the river to pleasant fields of rest, whilst others were kept away by long distances or urgent duties at home, but who in many instances responded in writing. Those who were present at this reunion of the class of 1876 will recall the pleasure which came from a few hours' association with old friends and how old hearts were made young by a revival of the student spirit and reminiscences of student life.

Class reunions are quite common in other large institutions of learning and have been largely instrumental in building up the interests of the alumni in the work of these schools. The extent of this interest is best shown at Harvard, Yale and Princeton, where the alumni spirit runs so high that large contributions have been made to various departments of educational work by the alumni of these schools.

So much can be done for the University of Maryland by its alumni that the BULLETIN would urge these class reunions as the first step towards a revival of a University spirit among its alumni. The time has come in the history of the University when a narrow and critical spirit should give way to larger and broader views of the University's future. The present faculty has shown a willingness to do all in its power for the good of the school and for the success of its alumni. The alumni should gather around those in present charge of the conduct of the University and encourage the efforts that are being made to broaden and liberalize the work of progress now in force. A new day is dawning for the old University. Let all of her friends give a helping hand and a hopeful encouragement to the purposes which now guide her policies.

GROWTH OF THE UNIVERSITY HOSPITAL.—Eight years ago when the new University Hospital was opened for patients it was believed by the friends of the University that it was large enough to provide for the accommodation of all patients that could be influenced to enter the Hospital for years to come. Some thought that the faculty had overreached itself in erecting such a large and costly building. To show how rapidly the work of the Hospital has developed it is only necessary to state that the present capacity of the Hospital is so crowded that it will be necessary during the present fall to open an annex to provide for the overflow, and during the coming year it will be necessary for the faculty to consider the advisability of building a large addition to the Hospital on ground now owned by the University adjoining the Hospital on the west.

Some idea of the growth of the Hospital may be obtained from the statement that at the present time between seventy and eighty pay patients are being treated in the private rooms and pay wards, and every bed not thus occupied is taken with State and city patients. Eight years ago thirty-two nurses were sufficient to do the work of the Hospital. At this time fifty-five nurses are hardly sufficient for this work. The amount of surgical work is best shown by the fact that not infrequently as many as ten operations requiring anæsthesia are performed daily by the surgical staff. In the accident and outdoor departments the work is equally as heavy, showing a large increase in clinical material at the command of the clinical teachers. This growth in the clinical work of the University is an evidence of the advantages the University offers to its students as a clinical school, and it can be stated without fear of contradiction that no medical school in this country can give to its classes of students a larger percentage of clinical material per student than the University is now giving. The growth of the student-body

is keeping pace with this growth of Hospital material, and it will be necessary for the faculty to provide for the further development of educational advantages. We believe the faculty is alive to present as well as future conditions connected with the growth of the school and that it will measure up to the requirements of the times. Baltimore is becoming more and more a center of medical education, and the schools of this city should fully realize the advantages which are here presented for the development of this educational feature in the rapid growth which Baltimore is making as a center of manufacture and commerce. The BULLETIN has already called attention to the striking advantages which this city presents as an educational center and has urged the medical schools here to make provision for the education of the medical student along progressive lines. There should be no rivalry between our medical schools for the student. The legitimate rivalry should be along lines of equipment and in the advance of the educational standard. The medical schools of this city should aim to give the very best instruction that can be given to utilize the large clinical resources of the city, and to offer to the student the most attractive and thorough courses of instruction demanded by the times. If this policy is adopted all of our leading schools will prosper, and those that do not live up to this standard will be weeded out. The BULLETIN does not question the right of any body of men to engage in educational work, but it does maintain that only the fittest can survive in the contest for advancement and in the confidence of the public.

ABSTRACTS AND EXTRACTS.

REMOVAL OF OVARIES FOR INOPERABLE CARCINOMA.—Dr. Hugh Lett, from an analysis of 99 cases (*Lancet*, January 28, 1905), reports that a considerable number had been followed by marked improvement in the patient's condition, both local and general. There was very marked improvement in 23.2 per cent., and distinct, though less, marked improvement in 13 other cases. The benefit was mainly shown in relief from pain, marked improvement in health, diminution, or even disappearance, of the growth, healing of ulcers and prolongation of life. In no case did "cure" result, with one possible exception (patient alive and well five years after operation). In 15 cases the improved condition was maintained for more than 12 months, and four others had good health 4¼ or more years. If a growth which was fixed and inoperable before oöphorectomy became smaller and movable after operation, it was advisable to excise it very freely as soon as the resulting improvement ceased to be definite.

EMPYEMA OF FRONTAL SINUS.—Dr. Richard Hall Johnston (1894) reported a case of this at the recent meeting of the Medical and Chirurgical Faculty in Baltimore. A man, aged 30, had a mild attack of "grip" in January, 1904, from which he recovered, but two weeks later he was taken with a severe pain over the left eye. This pain recurred every other day at noon or within the next four hours, lasting five to six hours; occasionally, if quiet, the pain was delayed a day. It began in the left temple, becoming agonizing with greatest intensity at supra-orbital notch, gradually subsiding. Empyema of the frontal sinus was diagnosed from: 1. Dryness of mucous membrane of left nostril; 2. Periodicity of pain; 3. Pain following acute infectious disease; 4. Tenderness on pressure of affected side. *There was no pus in the nasal fossa, and had never been any discharge from the nose.* The patient consenting, the frontal sinus was opened, and pus and a degenerative mucous membrane were found. This was carefully curetted out and the walls carefully examined for necrosis. Headache disappeared permanently. Such cases of closed empyema of the frontal sinus are very rare. The case was cited on account of the difficult diagnosis and as an illustration of intermittent periodic headache, which could not have been cured without operation.

NOTES AND ITEMS

Dr. W. J. McDowell, class of 1874, died at his residence in Baltimore, August 3, aged 51.

Dr. L. J. Sutton, class of 1854, died at Hyattsville, Md., June 11, aged 73.

Dr. W. M. Hammond, class of 1845, died at Rosedale, Kansas, April 27, aged 87.

Dr. W. B. Beach, class of 1875, died at Long Branch, N. J., April 19, aged 54.

Dr. C. T. Harris, class of 1904, died at Roxboro, N. C., July 6, with typhoid fever.

Dr. T. C. Moore, class of 1902, is located at Tallahassee, Fla.

Dr. C. W. Gardner, class of 1901, of Boston, Mass., is now taking a post-graduate course in the University.

Dr. Morris Robins, a former associate of medicine in the University, is now located in Spokane and doing well.

Dr. C. T. W. Sappington, class of 1903, is taking a post-graduate course in gynecology at the Johns Hopkins Hospital.

Dr. W. W. Goldsborough, class of 1901, has been nominated by Democrats as State Senator in Caroline county, Md.

Dr. D. Jenifer, class of 1904, a resident physician in the Atlantic City Hospital, is now spending his vacation at his home, Loch Raven, Md.

Dr. H. K. Deer, class of 1881, of Hagerstown, Md., was married August 3 to Miss Louisa McCoy at Washington, D. C.

Dr. A. Aldridge Matthews, class of 1900, late superintendent of the University Hospital, now located in Spokane, Wash., has made a recent visit to his old friends in Baltimore.

Dr. L. Wardlaw Miles, class of 1897, Ph.D., of the John Hopkins University, has been appointed instructor in English at Princeton University.

Dr. James B. Amos, class of 1854, one of the oldest practitioners of Pennsylvania, died at his home at Muddy Creek Forks, York county, August 20, aged 79.

Dr. S. P. Latane, formerly superintendent of the University Hospital, but now a resident of Winchester, Va., will be married on November 5 to Miss Bessie Love, daughter of Dr. W. S. Love, of Winchester.

Dr. J. C. Hemmeter, who has been summering at his residence at Walbrook, recently met with a painful accident by being thrown from a buggy by an uncontrollable horse.

Dr. George S. Hicks, class of 1899, who was mustered out of service as surgeon-major of volunteers in the United States Army, is now surgeon in the United States artillery corps.

Dr. Calvin T. Young, class of 1902, of Tampa, Fla., is spending a month in Baltimore. He reports that Rollin Jefferson, Jr., class of 1902, is meeting with success as a specialist in eye and ear diseases in Tampa.

Dr. Milton R. Walter, class of 1892, associate professor of histology, and a most successful teacher, has decided to sever his connections with the University and will try his fortunes in the West. Dr. Walter will locate in Chicago, Ill.

Dr. Roger Brook, class of 1887, of Sandy-spring, Md., whose professional career has been eminently successful, is a great admirer of his alma mater and heartily approves of every effort of the faculty to increase her efficiency.

Dr. E. J. Bernstein, class of 1887, chief of clinic to the professor of nose and throat diseases, has removed to Kalamazoo, Mich., where he will practice his profession. Dr. Bernstein is an industrious and conscientious practitioner, and the BULLETIN wishes him success in his new location.

Dr. James H. Wright, class of 1892, director of the pathological laboratory of the Massachusetts General Hospital, and an instructor in the medical school of Harvard University, who has made valuable researches in the bacteriology of actinomycosis and the aleppo boil, had bestowed upon him at the last Harvard commencement the degree of "Bachelor of Science."

Dr. V. M. Reichard, of Fair Play, Md., a great friend of the University, and a busy practitioner, is doing a public work entitling him to great praise and worthy of emulation. He is demonstrating how good roads can be made at a small cost. He has been elected supervisor of roads for his district and is experimenting in road building at his own expense.

Dr. R. H. Smith, class of 1875, has practiced since graduation in Harve de Grace, Md., and is one of the most active and successful physicians in Harford county. Dr. Smith is an occasional visitor to the Hospital and a warm friend of the old University. After thirty years of hard work as a country practitioner he is as vigorous in mind and body and as full of energy and push as a recent graduate.

The following graduates of this University were successful at the June examinations of the Maryland State Board and obtained licenses to practice:

Samuel S. Bare, Robert P. Bay, Charles M. Beuver, James S. Billingslea, Ira Barus, Sydennal R. Clark, John M. Elderdice, L. J. Goldbach, Samuel W. Hammond, Henry C. Houck, Brooke I. Jamison, Jr., Francis W. Janney, Eugene Kerr, Vernon F. Kelly, William A. Knell, George W. Mable, Harry D. McCarty, John D. Moritz, Roscoe C. Metzel, Robert L. Mitchell, John W. Pierson, Daniel E. Remsberg, Samuel T. T. Revell, John L. Riley, Anton G. Rytina, Albert L. Sanders, Holmes Smith, Jr., W. Henry Smithson, Jr.

Dr. John J. R. Krozer, of the class of 1848, has practiced his profession continuously for over fifty-six years, and to judge him by his present mental and physical vigor, and by the active and useful life he leads as a general practitioner, we should say that he has many years of good work before him. Dr. Krozer is a native of North Carolina, and was born in Elizabeth City, August 30, 1827. He is the son of Dr John Krozer, a prominent physician of his day. He was educated at the Military Academy, Portsmouth, Va., and was a student of medicine in the United States Naval Hospital near that city before entering the University of Maryland. Dr. Krozer located in Baltimore after graduation, and has for years enjoyed a large general practice. He is a gentleman of polished manners and refined tastes, beloved and respected by all who know him. Few men of his age enjoy the robust health and freshness of matured manhood to the same degree. Few have lived to better purpose and in an unostentatious and quiet manner of living have practiced medicine with greater honor. That many more years of active work may be vouchsafed to this distinguished alumnus is the best wish the BULLETIN can express.

At a meeting of representatives of the University of Maryland, St. John's and the Maryland Agricultural College, September 13, 1905, at the Governor's office in the Fidelity Building, Baltimore, Md., held for the purpose of devising ways and means of consolidating these schools, a resolution was adopted favoring a combination of the schools into a University, of which they shall be constituent parts without sacrificing their present individual charters and identity. A sub-committee was authorized to be appointed by the chair, consisting of one representative from each of the institutions interested, to formulate a plan for the organization of such a University, the plan to be submitted to the committee at as early a date as possible for its consideration. The following committee was named to prepare the plan of organization: University of Maryland School of Medicine, Dr. Randolph Winslow; University of Maryland School of Law, William T. Brantly; St. John's College, J. Wirt Randall, chairman; Maryland Agricultural College, Charles H. Evans.

Owing to the more rigid educational requirements demanded of schools, members of the Association of American Medical Colleges, a large number of prospective students, according to a report of our Dean, have been refused matriculation.

In the year 1899, a Syrian, Halibi by name, a student from the Syrian Protestant College, located at Beirute, Syria, received the degree of M. D. from our University. Since then a year has not passed without one or two Syrians or Egyptians receiving a diploma. The locations of our Eastern alumni are:

Dr. A. N. Halibi, class of 1899, of Jerusalem, is now superintendent of the Russian Hospital at Damascus.

Dr. N. S. Tacy-ud-diu, class of 1900, of Mt. Lebanon, is a surgeon in the United States Army, and is stationed in the Philippines.

Dr. C. D. Anawati, class of 1900, is practicing in Alexandria, Egypt.

Dr. George S. Hanna, class of 1901, lives in Tanta, Egypt.

Dr. M. Y. Hassun, class of 1901, Syria, is with the English Army in the Soudan.

Dr. T. A. el Rasy, class of 1902, Shailstaba, Syria, after taking the medical board at Constantinople, practiced at his home for a year, but he is now a lieutenant in the English Army, and is stationed in the Soudan.

Dr. S. A. Khuzami, class of 1903, from the town of Amyoun, Mt. Lebanon, Syria, who has been practicing among the Syrians of New York, expects in the near future to take the medical board at Constantinople, visit his home in Syria, and then join the English Army in Egypt.

Dr. N. S. Cotran, class of 1903, of Akar, Syria, is a first lieutenant in the English Army and is located in the Soudan.

Dr. A. A. Atiyah; class of 1904, Byom, Syria, is a first lieutenant in the English Army. He is stationed in the Soudan.

Dr. A. Ezzot, class of 1904, has taken unto himself a wife, and is practicing his profession in his native city, Cairo, Egypt.

Dr. F. Saad, class of 1904, is practicing at Mutioh, Egypt.

Dr. N. Kenaway, class of 1905, has settled in Alexandria, Egypt.

Dr. K. Kouri, class of 1905, is from Mt. Lebanon, Syria, but has joined the English Army as a surgeon, and is at present in the Soudan.

Since the Spanish-American War, there has been a great influx of Cubans and Porto Ricans into our school; consequently it will not be amiss to note the present location of those who have graduated.

Drs. C. W. and A. L. Bartlett, class of 1904, of Santa Clara, Cuba, are now residents of Tampa, Florida. The elder is the chief of that city's health department.

Dr. M. Fossas, class of 1903, of Porto Rico, is superintendent of the Bayamon Hospital, Porto Rico.

Dr. L. G. Quevedo, class of 1904, is a surgeon in the Porto Rican Provisional Regiment.

Dr. F. Villarvils, class of 1903, a Spaniard who fought in the Spanish Army at Santiago, is living in Porto Rico.

Dr. J. V. Somodevilla, class of 1904, Santiago, Cuba, has not located yet.

Dr. M. Dueno, class of 1905, Porto Rico, is employed by the United States Government to investigate aulsylostoma duodenalis in Porto Rico.

Even before 1898 we had enrolled upon our register students from those sunny climes, some of whom have become quite celebrated, *i. e.*, Dr. Jose L. Romero, class of 1879, Santiago, Cuba.

Dr. Jose R. Espin, class of 1856, a noted physician of Santiago, Cuba. During one of the insurrections he was murdered by the Spaniards.

Pastor Y. G. Burgos, class of 1880, Cuba.

Gabriel Gimenez, class of 1875, Porto Rico.

Albert T. Sinemous, class of 1864, Cuba.

Arternio A. Umpierres, class of 1876, Porto Rico.

Besides these alumni there are a number of citizens of these islands now students in the University.

J. M. Infante, class of 1906, Santiago, Cuba.

J. del Toro, class of 1906, San Juan, Porto Rico.

A. Soler, class of 1906, Aguadilla, Porto Rico.

S. Duteil Ginliani, class of 1907, Vieques, Porto, Rico.

Manzouet, class of 1907, Porto Rico.

J. Morander, class of 1908, Santiago, Cuba.

R. Rodriguez, class of 1908, San Juan, Porto Rico.

Bush, class of 1909, Santiago, Cuba.

Santaeye, class of 1909, Porto Rico.

J. G. Dominguez, class of 1907, of Mayagues, died shortly after completing his first term.

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NEPHRECTOMY FOR RENAL TUBERCULOSIS, WITH A BRIEF REPORT OF THIRTEEN CASES OF NEPHRECTOMY; MORTALITY FOLLOWING OPERATIONS NIL.

BY FRANK MARTIN, M.D.,

Clinical Professor of Surgery, University of Maryland.

(Continued from last issue.)

Case IX.—Primary carcinoma of kidney, right. Operation: Nephrectomy—transperitoneal route. Recovered.

Miss A. M., aged 53, residing at Clear Springs, Md.; referred by Dr. Abraham Shanks.

Family History.—Cancer, mother having died of cancer of stomach.

Previous History.—Negative.

Present History.—Patient states that for the last 20 years she has had at times violent abdominal pains. Of recent years attacks of pain have been so violent in character that sleep was interfered with for weeks at a time and attended by vomiting spells. Patient was not confined to her bed at any time, but was able to be about. These symptoms continued until last fall, 1902, when they became greatly exaggerated, at which time patient began to pass blood with the urine. This would clear at times and then be of a solid coagulated character, the urine very offensive. This condition continued and the bloody urine became practically constant. She entered the University of Maryland Hospital for the relief of this bloody urine, to determine the cause of it, and get relief.

Examination.—Upon examination on entrance it was found by palpating the abdomen that there was a large mass to be felt in the region of the right kidney. The patient was unaware of this enlargement. I came upon it on my first examination in going over the abdomen, so just how long it had been present it is impossible for me to say, as patient did not know of its presence. This mass was of a large size, filling the space between the ribs and the ilium below. Patient was short and stout, and the space between the ribs and the pelvis below was rather short. It was not especially painful to the touch; some tenderness on pressure; was more or less fixed; no mobility noticed in it. There was no apparent loss of weight; patient seemed well nourished, with a good deal of adipose tissue.

Blood Examination. — Leucocyte count 9000; red cells 4,500,000; temperature upon entrance was normal; pulse 108.

Examination of Urine. — Urine of dark-red color, filled with blood; acid, specific gravity 1020; thick sediment; no sugar; albumen; abundance of pus cells; a few hyaline granulation casts. The principal thing to be noted about the urine was the immense amount of blood that was passed with it, and this had been going on apparently, from the patient's say so, for a considerable time.

Diagnosis.—With the history of pain, the enlargement and the bloody urine, I made a diagnosis of a neoplasm of the kidney, of a possibly malignant character.

Operation.—April 24, 1903; ether; right-rectus incision; peritoneum opened; large mass was discovered in the right side of the abdomen, high up. It was covered by the omentum and mesentery, somewhat movable. After uncovering it, tucking off the intestines, it was found to be a large growth of the right kidney. All the vessels were enormously distended. All through the mass and in the mesentery adjoining it were found these enlarged vessels. After tying off the large vessels and opening the peritoneum over the growth, the kidney was dissected up, the vessels were ligated off separately, and so likewise the ureter and the kidney removed. An opening was made in the back between the last two ribs, and gauze drainage put in to drain the area from which the kidney was removed. Abdomen was closed without drainage, and patient went off the operating table in good condition. There was an uneventful recovery; no aneuria. Urine was scant immediately following the operation, but the other kidney did

its compensatory work very well. Patient was up in the course of two weeks, and left the Hospital in good condition about four weeks after operation.

Note: A letter received from Dr. Shank on March 7, 1905, relative to this patient states: "Her general condition appears to be fairly good; has not lost any weight, and the quantity of urine about normal. I procured a specimen, and found it with a specific gravity of 1020; acid; no albumen and no sugar. She certainly does not have the appearance of one suffering from any malignant disease at present."

Gross Appearance of Specimen.—The kidney is much enlarged throughout; more so at its upper pole, where more of the growth seems to be; here it was enormously enlarged. The cut section of the kidney shows what looks clinically like a typical scirrhus carcinoma.

Microscopical Report.—This was made by Dr. Hirsh, the pathologist, and shows typical carcinoma.

Case X.—Painful movable kidney, right. Operation: Nephrectomy. Previously in West Virginia she was supposed to have had a nephrorrhaphy done, though I could find no evidences of it at present operation. Cured.

Mrs. B. L., aged 53; referred by Dr. L. N. Harris, of West Virginia.

Family History.—Negative.

Previous History.—Negative.

Present History.—Patient entered University of Maryland Hospital July 17, 1904, with a history of having had pain in the region of right kidney for the past five or six years. Three or four years prior to her coming to me she was supposed to have been operated on for a movable kidney (in West Virginia), a nephrorrhaphy being done, but she continued to suffer pain in this region. The attacks of pain became more and more severe, until at present time it is beyond her endurance.

Examination. — This reveals some tenderness over the right kidney on deep renal palpation, and apparent mobility of the organ is noticed. Patient is enormously stout, weighing somewhere between 200 and 300 pounds, and no definite knowledge can be obtained by abdominal palpation on account of the enormous size and fattiness of the abdominal wall.

Examination of Urine.—Negative.

Examination of Blood.—Negative.

Diagnosis.—Painful kidney on the right side.

Operation. — July 22, 1904; ether; abdomen opened through the right rectus; enormously thick abdominal walls, fat four or five inches deep; kidney found to be slightly enlarged and somewhat movable; appendix was found to be chronically inflamed, so it was removed. Before closing the incision in front, on account of the depth of the kidney and the inaccessibility of the organ to be gotten at through the front, with my hand in the abdomen I made a lumbar incision and removed the kidney by the lumbar route, and the abdomen was closed without drainage, and the back incision was closed, save for a small wick of gauze drainage. She made an uninterrupted recovery, and left Hospital markedly benefited.

Case XI.—Large cystic kidney, right. Operation: Nephrectomy. Cured.

Mr. J. H. S., aged 39; referred to me by Dr. F. S. Orem.

Family History.—Negative.

Previous History.—Negative.

Present History.—Patient was brought to my office on July 22, 1904, complaining of a movable mass in abdomen. Examination showed it to be a large cystic kidney, size of one's head. The mass had appeared a year previously and then disappeared. Nephrectomy was advised, and he entered the Hospital on July 27. After his entrance, previous to operation, the examination made revealed the fact that the mass in his right abdomen had gone down very perceptibly since the former examination from the size of one's head to the size of a large orange, and this was probably due, no doubt, to the ureter being relieved of its kink and a great quantity of the contents of the cyst having passed off in the form of urine. This enlargement could be noted by renal palpation. The man's abdomen was thin and very easily palpated.

Diagnosis.—Cystic right kidney.

Operation. — July 29, 1904; ether; abdomen opened by the right rectus incision. When the peritoneal cavity was entered there was noted an immensely dilated stomach, and a very large cyst of the pelvis of the kidney was found, and the entire organ removed through the front by the transperitoneal method. A small wick of gauze was left in the back for drainage of this large cavity from which kidney had been removed; abdomen closed without drainage. Patient made an uninterrupted recovery. Wound healed under

one dressing, and he left the Hospital three weeks after, entirely well.

Microscopic Examination. — Gross specimen shows markedly hydronephrotic kidney. The specimen has been kept intact and no sections made of it. The kidney structure itself does not seem to be involved. The cyst apparently goes off from the hilum of the kidney, the pelvis of the kidney being markedly dilated, and the ureter goes off from the dilated pelvis.

Case XII.—Sarcoma of the kidney. Operation: Primary transperitoneal nephrectomy. Recovered from operation, but died of general sarcomatosis.

G. D., aged 41, male, white; referred to me by Dr. J. W. DuBois.

Family History.—Negative.

Previous History.—Negative, except that he was treated for eight weeks for typhoid fever at the Johns Hospital Hospital, and says it was the first illness of his life. Six years ago was operated on by Dr. Tiffany for an infected arm.

Present History. — This dates back to eleven months ago. He had an attack of pain in the region of the umbilicus, which he thought came from his occupation, handling a fork on a farm and the fork handle pressed into his abdomen just to the left and a little above the umbilicus. Three months ago began to feel badly, and occasionally vomits; pain shooting through left side and back; latter improved, but pain in umbilical region continued; vomits at present after taking food; pain extends over left side, but is sharpest in a definitely located spot near the umbilicus and to left of vertebral column in the back; abdomen has at times been swollen, but not lately; never felt any mass in abdomen; has lost considerable strength and weight as well since he has been ill; form and symmetry of body: bones slender, well formed, no fractures; left elbow joint ankylosed in extension, result of an inflammation of the arm six years ago; muscles small, poorly developed and fairly soft; no atrophies or contractures: adipose tissue scant; body poorly nourished; skin pale; mucous membrane anemic; superficial glands not enlarged except inguinals, which are palpable.

Examination. — Inspection negative; tender point distinctly localized to the left of the umbilicus; pain is traced to the back just to left of fifth lumbar vertebrae; large mass is to be felt filling the left abdomen; quite tender on palpation.

Examination of Urine. — Urine dark, bloody, containing thick fibrous clots; seemed almost like pure blood; specific gravity 1020; heavy ring of albumen; full of red and white cells; no casts seen; has been passing bloody urine since December 1. Amount of urine in 24 hours 1100 c. c. December 8, urine not so bloody in appearance; complained through the night several times of having sharp pains down left ureter, so bad that he could not get relief for quite awhile; very much nauseated, but did not vomit.

Blood Examination.—Hemoglobin 70; red cells 4,320,000, white 12,250. December 10, 1904, although the patient had been advised to have an operation done for the kidney, he left the Hospital and went to his home in Anne Arundel county.

December 5, 1904, patient has grown much worse, and his pains have become constant in character, located in the region of his left kidney; mass in region of left kidney greatly increased in size; blood in urine markedly diminished.

Blood Examination on Re-entering. — Hemoglobin 67; red cells 4,000,000; leucocytosis 14,000.

Diagnosis.—Growth of kidney probably malignant.

Operation.—Transperitoneal nephrectomy; left rectus incision, extending down to within an inch or so of Poupart's ligament. This large incision was made on account of the large size of the kidney. There was found extensive involvement of the retroperitoneal glands and a chain of glands running under and around the abdominal aorta and vena cava. So extensive was the infection outside of the kidney that I at first thought it would be an inoperable case. I was afraid I would not be able to get the kidney away, because the renal vessels seemed to be infiltrated with cancer, and I was fearful I would tear into the aorta and vena cava in getting this large mass up. By tying off the large blood-vessels which ran over the mass the size of my finger, and by slowly dissecting down and tying off blood-vessels as I came to them, I was able to get the kidney up and remove it. This was done with great difficulty on account of the immense infiltration of the tissues around with sarcoma. An opening was made in the back, and small drain passed in there, and the front wound in the abdomen closed. Patient recovered from operation; wounds healed, but he grew steadily weaker, and in the course of five weeks died of sarcoma infection.

The weight of the kidney removed was a pound and a-quarter.

Microscopic examination showed it to be a sarcoma of the round and giant-cell type. Almost the entire kidney structure was made up of sarcomatous tissue; very little remains of the true kidney substance.

Post-Mortem Report.—Nodules of sarcoma were found through the liver, both lungs; mesentery glands enlarged; large nodules of sarcoma were found running along the vertebral column and extending around the aorta and vena cava. At the brim of the pelvis on the left side were large nodules of sarcoma; right side of abdominal cavity uninvolved; the pelvic glands along the left ilium vessels involved, and also the inguinal glands were invaded with sarcoma.

It rather looks as though the removal of the kidney made the growth of the sarcoma more rapid in the other portions of the body.

Case XIII.—Ruptured kidney. Operation: Primary nephrotomy and drainage of the kidney and perirenal tissues, as well as the abdomen, through a large lumbar incision; later a secondary lumbar nephrectomy. Cured.

J. S. B., aged 24.

Family History.—Negative.

Previous History.—Negative.

Present History.—This pertains only to his accident, as follows: On the 23d of November, 1904, he was helping at a building, and fell a distance of about 12 feet, striking his left side in the region of his left kidney on a crossbeam, profoundly shocked, and the following morning his abdomen began to swell, and he was taken with vomiting. Active hemorrhage was passed with the urine; he had marked pain over the region of left kidney; vomiting and tympanites continued, and the bloody urine, until I was called on the 26th of November.

Examination.—This revealed a very badly distended abdomen, tender to the touch all over, with special tenderness on the left side. On palpating the left side I could make out a definite resistance. The blood in the urine was not so noticeable, but it was a murky, muddy color, and under the microscope showed a number of red-blood cells. He was still having incessant vomiting.

Diagnosis.—I gave as my opinion that he had a ruptured kidney, and was threatened with a general peritonitis from the urinary infiltration, which was unquestionably present in the loin.

Blood Examination.—Leucocytosis 10,000. On entrance into the Hospital he had a temperature of 102 and pulse of 130.

Operation.—Under ether, a large lumbar incision was made over the left kidney, and on opening the tissues down to the deep fascia I came upon a large blood clot which was immediately outside of the kidney capsule. When this was opened into lots of blood clot were removed, and an ill-smelling discharge came squirting out, probably a pint of decomposed urine, which had infiltrated all the tissues around. Upon getting this evacuated and irrigating the wound well I came down upon a kidney ruptured and the greater part of it pulpafied, from which considerable hemorrhage was occurring. Many large pieces of kidney were lying in the bottom of the wound. I removed all the lacerated portion of the kidney, but the man's condition was so grave and the area of infiltration through his back so extensive, running down to the back of his peritoneum, that I did not think a complete nephrectomy at this time was justifiable; the kidney and the perinephritic tissue irrigated with salt solution, and a gauze tucking introduced, going well down in the pelvis and up in the back, and in between this and into the kidney proper a large tube was placed. It was impossible for me to make out a definite opening into the peritoneal cavity. This infiltrated cavity of blood clot and urine seemed to be post-peritoneal, but he was profoundly shocked and had evidence of beginning peritonitis. He reacted, however, after an intracellular salt solution was given him, 500 c. c.; vomiting subsided; temperature gradually took a downward curve; soreness and the distention of the abdomen improved, and pulse came down from 160 to 104 by the following day. The tenderness over the abdomen and distention gradually disappeared. He drained freely through the gauze drainage and the rubber tube in back. The bloody urine cleared up immediately after operation. Patient continued to improve, and left the Hospital December 31, 1904, wearing a tube into the disorganized kidney, with the opinion that if his kidney would heal so, all well and good; if not, he could return and have a nephrectomy done.

February 23, 1905, patient reported to Hospital, kidney not healed and was draining urine freely through the sinus in the back.

Examination showed large necrotic bit of kidney, and I concluded to remove by a nephrectomy the remains of the injured kidney.

Operation.—Under ether, on February 25, 1905, the old incision was opened up. Many adhesions were found tying the kidney up to the surrounding tissues. I had very little difficulty in getting the upper pole of the kidney, which was in fair shape, opened out from the surroundings, but the lower pole, which had borne the brunt of the injury, was intimately tied up in the intestines and tied down by adhesions, and there was very little of it left—a small bit about the size of the thumb. This communicated directly with the pelvis of the kidney, and in getting it up I opened into the peritoneal cavity, and some of the small intestines and colon bulged out in the incision. I could not segregate the ureter and the vessels so as to tie them separately on account of the adhesions holding them down, so I clamped them and cut away the kidney. The clamps included the ureter, artery, and the veins, and made such a huge hunk of tissue that I could not get a ligature around it. In trying to get a way around by sectioning it off I poked my Cleveland needle through a vein, which bled furiously, and in reclamping the veins seemed to tear loose near the vena cava and considerable hemorrhage came through them. So after all kinds of difficulty, patient not taking the anæsthetic at all well, I decided to leave the clamps on, as they controlled the hemorrhage, and I could not see a way of tying them in such a deep hole, so I left them on, four or five in number. The peritoneal cavity was stitched up by fine sutures, so as to retain the intestines in the peritoneal cavity; gauze tucking was then placed in the wound, leaving it widely open all around the forceps, and dressings put on around the forceps. He was placed on his bed on his right side and the forceps were not removed for probably 60 hours. He was kept on his right side all this while.

This was the first nephrectomy I have done that I have had to leave clamps on, but they answered perfectly well, and I had no further bleeding or further trouble. When the clamps were removed the wound was left lightly packed with gauze and healed by granulation. He left the Hospital in about four weeks in good order.

It will be observed that in this list of cases there are three cases of nephrectomies, all secondary lumbar nephrectomies, done for the relief of renal tuberculosis; two for unilateral cystic kidneys; three for unilateral painful kidneys; one for endothelioma of the adrenal gland; one for ruptured kidney; one for a carcinoma of the kidney; one for sarcoma, and one for the relief of a condition brought about by the ureter being accidentally cut across in a previous operation.

Four of the above were done by the transperitoneal method and the remaining nine by the lumbar route.

NON-DIGESTION OF NUCLEI IN MEAT FIBER: A CRITERION OF PANCREATIC DISEASE (INSUFFICIENCY).

By John C. Hemmeter, M.D., Phil.D., LL.D.,
Baltimore, Md.,

Professor of Physiology and Clinical Professor of Medicine, University of Maryland.

It is known from the interesting investigations of Prof. Adolf Schmidt that raw connective tissue can only be digested by the gastric juice, while the nuclear substance of meat fiber can only be digested by pancreatic juice. Hence the appearance of remnants of undigested connective tissue in the feces points to the insufficiency or absence of gastric secretion; and the appearance of nuclei cells in meat fibers is significant of insufficient secretion of pancreatic juice. Personally, I have tested the first deduction of Dr. Schmidt in eight cases of "achylia gastrica" and six cases of chronic "atrophic gastritis" with entire absence of free or combined HCl ferments. In all eight cases of achylia gastrica and in five cases of atrophic gastritis the undigested connective tissue fibers were found in the feces. In two cases of heterochylia (i. e., variable gastric secretion) hyperchlorhydria with excess of pepsin and chymosin alternating with absolute achylia in the same person after the identical test-meal. (See Ueber Heterochylie. (Hemmeter) von George Korn, Archiv f. Verdauungskrankheit. Bd. vii, 1902, S. 75). The undigested connective tissue fibers were found in the feces only during the periods of absolute achylia, when the gastric juice contained no ferments nor free or combined HCl. They disappeared from the feces in periods during which the gastric juice was normal. Two of these cases of heterochylia I have had under observation off and on for eight years; their feces and gastric contents were examined during a period of five or six weeks in the spring and fall of each year.

I might add that during the periods of absence of HCl and enzymes in the gastric juice no biuret reaction could be obtained in the gastric filtrates,

but the addition of 10 cubic centimeters of officinal dilute hydrochloric acid, together with one grain of pepsin diluted with distilled water to represent the concentration of hydrochloria in gastric juices, caused perfect digestion of connective tissue if persisted in for 48 hours; that is, at 0.2 per cent. (two per mille) solution of HCl with sufficient pepsin to approximate the concentration (amount) in gastric juice will cause disappearance of undigested connective tissue fibers from the stool. The amount of pepsin to be added varies with different meals, but cannot be definitely stated a priori. It should be added to gastric filtrate or chyme (10 c. c.) until the reaction of free HCl appears on titration with Congo and the Phloroglucin-vanillin test. Sometimes it is impossible for the patient to swallow such large quantities of dilute HCl. Then we occasionally succeed by giving the requisite amount of officinal HCl in large gelatine capsules, and directing the patient to drink the corresponding amount of water afterwards.

For studying the conditions of pancreatic secretion by means of its effects on the nuclear substance of meat fiber, Adolf Schmidt uses slightly fibrous beef, which is cut into small cubes of 0.5 cm. square, and preserves them in absolute alcohol. Prior to using them as tests they are immersed in water for three hours and given to the patient in wafers. The test diet which Schmidt recommends (Funktions prüfung der Darms mittelst Probekost, Wiesbaden, 1904) must be faithfully adhered to, and does not impose any inconveniences upon the patient. Personally I make use of an improved Boas stool sieve for regaining the little silk sacs. If the cases have any pancreatic disturbances, there must, of course, be remnants of muscle in the sacs. In the sifted stools of 12 healthy students no muscle remnants were ever found in 30 different tests. If muscle remnants are found they are washed in water, hardened in alcohol, sectioned if need be, and stained with nuclear stains. It is not, as a rule, necessary to harden the beef remnants; after rinsing them in water they can be directly treated with dil. acetic acid or methyl blue. Wallenfung studied these beef remnants after they had passed through the entire digestive tracts of dogs that had been deprived of their pancreas. In three dogs that survived total extirpation of the pancreas, the meat fibers regularly contained their nuclei and were readily stainable.

Preservation of the nuclei justifies the conclusion of pancreatic disease, or at least absence of pancreatic juice from the intestines (the two conditions are not always identical) only, if the time of the passage of the meat was of a normal period. A very rapid passage of the sacs, such as occurs in diarrhoea, frustrates the action of the trypsin, even if it is present.

In two cases of pancreatic abnormality this test worked satisfactorily. One was a large pancreatic cyst, compressing and obliterating the duct of Wirsung. A second case was stenosis and adhesions of this duct by an old pericholecystitis, an extension of a preceding choleithiasis. In the first case the pancreas itself did not appear seriously diseased at the operation; it seemed that its entire secretion was collected into the huge cyst, the contents of which had the same physiologic and chemic properties as a similar case closely studied by me in 1898 (Hemmeter and Adler, "A Chemic and Physiol. Study of Pancreatic Cyst Fluid, etc., New York *Med. Record,* Aug. 6, 1898). Both cases recovered after operation, and six weeks thereafter no nuclei could be discovered in the stools.

Adolf Schmidt believes that his test, when combined with the test of Sahli, will facilitate the diagnosis of pancreatic disease, and if I may speak from my rather limited experience thus far it must be in confirmation of his conclusions.

CORRESPONDENCE.

A TRIP TO ALASKA.

To the Hospital Bulletin:

From Baltimore to Alaska is a long step, and but few make the journey. We in the East are accustomed to think of Alaska as a remote, inaccessible and inhospitable portion of the globe, inhabited by Esquimos and a few rough characters seeking gold. The country itself is supposed to be barren and of frigid temperature, and the conditions of life exceedingly hard.

I had long entertained a desire to visit this part of our territory, with but faint expectations of realizing it. The comparative proximity of Portland to Alaska, however, offered me an opportunity of making the trip, and I could not resist the temptation to do so. The steamship Jefferson had been specially chartered for a doctors' excursion, but every berth was taken long before the meeting of the Association, and all the other boats sailing about the same time were also packed. I secured tickets for the steamship City of Topeka,

sailing from Seattle on the 18th of July. Leaving Portland on the 16th, I retraced my steps to Tacoma, situated at the lower end of Puget Sound. This is one of the rapidly-growing Western cities, full of bustle and activity, placed on high hills overlooking the water, with handsome homes. An enjoyable trip up the sound on the steamer Flyer to Seattle added interest to the journey. The American lines to Alaska take their departure from Seattle, but there are also ships sailing from Vancouver in British Columbia. Seattle is one of the most attractive and prosperous cities in the West. The citizens estimate its population at from 150,000 to 175,000, and it certainly covers a vast area. It fronts on Puget Sound and extends back over lofty hills to Lake Washington, a beautiful body of water, which affords excellent opportunities for boating, bathing and fishing, whilst parks and pleasure resorts line its shores, and in the distance, when the weather is clear, Mts. Ranier and Baker rear their hoary heads into the cerulean sky. Green Lake and Union Lake are large bodies of water within the city limits. The houses are not closely built, as with us, and with gardens surrounding them and flowers in profusion a charming scene is presented. On the sound an extensive commerce is carried to the gates of the city. It is said the foreign commerce of Seattle is already equal to that of San Francisco, and is constantly increasing, the land-locked harbor and shorter route to the Orient giving Seattle great advantages in its bid for trade.

The huge Pacific lines of James J. Hill and the Great Northern Railroad, upon which Baron Komura came to this country, sail from Seattle to the Orient, and are the equal in size and equipment to those on the Atlantic coast.

Seattle has a bustle and activity in its business portions suggesting Chicago, with handsome hotels and abundant street-car lines, many of which are drawn by cables, owing to the steep hills over which they pass. The streets are wide and paved with bricks, wooden blocks, planks, asphalt or simple macadam. There are several excellent private hospitals, but the most remarkable institution for the care of the sick I have ever seen is the City Hospital. This is an old steamboat drawn up on shore, with its machinery removed, and the decks and saloon made into wards. The pilot-house was a private room for a female patient. The wards were overcrowded, and I was told the capacity of the boat was 40 patients.

In the interval of waiting for my steamer I took a trip across the sound to the United States navy-yard, which is situated up a narrow stream, well hidden and protected, and then broadening out into a bay, affords ample space for a large fleet to assemble. Here, and at Tacoma and Portland, I found many of the ships made famous by their participation in the battle of Manila bay.

Our ship was advertised to sail at 9 P. M. on July 18, but it did not get off until 1 A. M. on the 19th, owing to the large amount of freight. From the great number of beer kegs taken aboard it is evident that the Alaskans are thirsty souls. When we awoke in the morning we were at Port Townsend, at the upper end of Puget Sound, which is the port of entry for all boats entering and leaving these American waters. Here the customs inspectors and quarantine officials examine the ships. The statement is made, with what accuracy I do not know, that more vessels clear from Port Townsend to foreign ports than from any other port in the United States. Separating the State of Washington from Vancouver Island is the Strait of Juan de Fuca, about 30 miles wide, through which the ocean-bound vessels must pass. The trip up the sound and across this strait is very charming, the beautiful water sparkling in the sunshine like millions of sapphires; the green-clad hills and emerald islands and the snow-capped mountain ranges on each side constitute a panorama not to be soon forgotten.

Vancouver Island is nearly 300 miles in length and about 50 in width. At its lower end is situated Victoria, a charming city of 30,000 inhabitants, the capital of British Columbia. Between the island and the mainland is the Gulf of Georgia, a wide body of water, which gradually narrows into Johnstone Straits and then expands into Queen Charlotte Sound. The city of Vancouver is situated on the mainland in British Columbia, and is the terminus of the Canadian Pacific Railroad. It is a typical English town of 45,000 inhabitants, and is rapidly increasing in population and importance.

The voyage from Seattle to Skaguay, a distance of 1000 miles, is almost entirely in land-locked waters, except for short distances at the upper end of Vancouver Island and across Dixon Entrance, where the Pacific Ocean has an unobstructed sweep, and many passengers get a taste of seasickness. The scenery is grand—the placid waters, the mountains on both sides, clad with evergreen and sloping to the water's edge, and in the dis-

tance the loftier ranges, eternally snow-topped, with here and there, as we go north, glaciers discharging their cargoes of icebergs into the sea, or tumultuous streams fed by the melting snow, and rushing down the mountain sides, leaping at times hundreds of feet over precipices, all constitute a picture which can scarcely be duplicated in any other part of the world. At the mouth of the Frazier river we passed at least 2000 boats, largely manned by Siwash Indians, fishing for salmon; but as we proceeded north the evidences of human habitation are but few. Here and there a solitary hut or a group of huts are seen, weirs and nets in the nearby streams, or a canning factory, or a quarry or mine, but the country is desolate. In these lonely parts it was a comfort one evening to see two United States cruisers and a torpedo boat anchored; it was like meeting a friend in a strange city.

Our ship's company was quite cosmopolitan; there were a number of physicians and their wives, but also laymen, prospectors and business men on board. The ship was crowded, and in No. 18 stateroom were two other physicians and myself. One of these doctors had been a student at the University of Maryland in the 80s, when I was demonstrator of anatomy, and the other was a graduate of the College of Physicians and Surgeons of this city. Two young ladies whose acquaintance I made were nurses trained at Dr. Barnard's Sanitarium on Charles street.

The weather continued beautiful, warm enough to wear light summer clothing without an overcoat in the daytime, but getting cooler in the evening when the sun set. At 9 P. M. it would still be bright daylight, and darkness came on after 10 o'clock. Northward we go for three days, and on awakening on July 22 we are in American waters again and are no longer foreigners.

Southeastern Alaska is a narrow strip of mainland, with outlying islands, reaching far down between British Columbia and the Pacific Ocean and extending inland only to the top of the mountains. It is a very rugged country, rich in mineral wealth, but unsuited for agriculture. The hills and mountains are covered with spruce and fir trees, and there is a considerable lumber industry. Mining, milling and canning are the chief productive occupations of this part of the country, whilst farther north, in the Aleutian Islands, the seal fisheries, are of immense value. On the southern coast the extremes of weather are not marked. In summer the temperature is usually moderate, about 65° to 70°, whilst in the winter it is not very cold. The long days of summer are favorable for work, but the short winter daylight is inconvenient and depressing.

Flowers were growing in profusion in the yards and on the mountain sides, and many vegetables, as peas, beans, tomatoes, cabbages and potatoes, seemed to thrive well. I saw some wheat at the fair in Portland, raised in Alaska, but it is not likely that cereals will flourish in such a climate.

RANDOLPH WINSLOW.

The General Alumni Association of the University of Maryland, the president, Dr. Wilmer Brinton, class of 1876, in the chair, held its ninth stated meeting and smoker at 847 North Eutaw street Thursday, October 19, 1905. Dr. Eugene F. Cordell, the secretary-treasurer, reported the endowment fund of the University has passed the $7000 mark, and he has hopes that by 1907, the centennial year, by a thorough canvass of the city it will have reached $100,000. This society has been steadily increasing in numbers, so that there are now 150 active and nine honorary members. As all alumni, i. e., pharmacy, law, dental, medical, become eligible to membership by simply sending dues ($1) to Dr. Eugene F. Cordell, 855 North Eutaw street, Baltimore, it is hoped all will join. Gordon Wilson, M.D., associate professor of clinical medicine, and Prof. Theodore Hemberger were elected honorary members of this society. "Old Maryland" was made the official organ of this association and authorized to send it free of charge to every member, the association bearing the expense of publication. Before the meeting adjourned short addresses were delivered by Prof. Randolph Winslow, M. D., on his trip to the North and West; by Prof. Henry P. Hynson, Ph.G., on the American Pharmaceutical Society and the United States Pharmacopeia, dwelling especially on the standardization, adulteration of drugs, incompetent practice of pharmacy and best forms of officinal preparations, and by Prof. Charles Caspari, Jr., Phar.D., on the revision of the American Pharmacopeia.

The BULLETIN is glad to hear that Dr. Arthur D. Mansfield, 1890, of Owings Mills, Baltimore county, who had such a narrow call from an anthrax infection of the neck, is convalescing.

ABSTRACTS AND EXTRACTS.

In an article upon the "Diagnosis and Treatment of Renal Tuberculosis" by Prof. Randolph Winslow in the August number of *Gaillard's Southern Medicine* the common symptoms are duly noticed, but especial stress is laid upon the renal symptoms being marked by reflex bladder irritation; therefore the writer warns all practitioners when dealing with bladder cases to bear in mind the possibility of tubercular nephritis, as early operative intervention offers the only hope of relief. Before operating, the author advises the surgeon to make use of all the modern scientific appliances, such as the hemocytometer, the cystoscope, ureteral catherization, skiagraphy and the examination of the urinary sediment for tubercle bacilli, in order to confirm his diagnosis.

Although renal tuberculosis is always fatal, no case ever having recovered, Dr. Winslow says early operative treatment will often prolong the patient's life. If the patient's condition warrants, nephrectomy ought to be performed. When the diseased kidney is diagnosed, even if the opposite organ is slightly involved, this procedure is permissible. From the foregoing remarks it will be seen that early operative treatment is indicated as soon as unilateral tuberculosis of the kidney can be determined. This is the time to remove the organ with least danger and best prospects of prolonging the patient's life. Where there is extensive suppuration, or the patient's condition does not warrant a removal, then do nephrotomy. Two methods may be employed to remove the kidney, the lumbar and abdominal. It is generally preferable to use the former.

A New View of Sleep.—Dr. A. K. Bond, of this city, class of 1882, has a most instructive article in the October number of the *Maryland Medical Journal* with the above title. We give his conclusions:

"Sleep, then, is the primal state of the human body and brain under which it was originally built into its type outlines. It is a state which is experienced in common with all plant and animal life.

"From this primal sleep the body is aroused when sufficiently developed by internal and external stimuli into a state of awakeness, intense in proportion to the sensitiveness and power of its brain. Thus in the lower animal the activities of awakeness are much less extensive than in man, the brain being developed only so far as to be responsive to the lower stimuli of hunger, pain and the like.

"In man, however, to these lower incitements to activity, shared with the animals, are, as his brain becomes more powerful, added stimuli apparently unknown to lower animals. He no longer subsides as the infant and the animal into sleep when hunger and pain are absent, but becomes liable to subjective brain sensations, intense in proportion to the sensitiveness and specialization of his brain cells. Light no longer simply warms him, but stirs him to the contemplation of its source and nature and to inventions for determining these facts. And when the external stimulus is withdrawn he is still stirred to awakeness by the intense memory of its phenomena.

"And not only are external stimuli more widely and permanently exciting to his brain, but apparently the brain itself can frame from memories of past phenomena and from its own recesses (which we cannot ourselves penetrate) most extensive and stirring incentives to awakeness. Thus the sense of duty (wholly subjective apparently) wields a lash more keen and irritating even than hunger itself.

"There is likewise a pleasure of activity attached to every bodily and mental function in its normal exercise which stirs us at times to longer wakefulness.

"Thus, as we analyze them, all of the phenomena of awakeness fit one by one into the theory which I have adduced in the preceding pages."

Typhoid Appendicitis Without Other Intestinal Lesions.—In an interesting article in the *Johns Hopkins Hospital Bulletin*, August, 1905, Dr. Wm. Royal Stokes, a former pupil and instructor in the University, and Dr. Albert L. Amick report a case in which they isolated the bacillus typhosus and bacillus pyocyamus in cultures taken from the lumen of the appendix. As no other organisms were present and the disease was unassociated with any other intestinal lesions, they concluded that their case is one of primary typhoid appendicitis. This case had typhoid fever 13 years before the present attack of appendicitis. It is not rare to meet with either simple appendicitis or appendicitis with the lesions of intestinal typhoid during an attack of enteric fever, but they claim this to be the first authentic case of primary appendicitis caused by the bacillus typhosi.

THE THYROID AND PARATHYROID GLANDS.—In the September 2, 1905, issue of *American Medicine* Dr. Hubert Richardson's new book on the thyroid and parathyroid glands is, on the whole, very favorably criticised, the critic mentioning that it is well written and accurate, that the sequence of the 14 chapters is logically and systematically arranged. A special chapter is devoted to the surgery of the thyroid gland, and one to the thyroid feeding as applied to general therapeutics. The reviewer recommends it to the medical fraternity for its succinctness and brevity, but says: "Reading the book is made difficult by the poor arrangement of the illustrations and lack of reference to them in the text."

PENETRATING WOUNDS OF THE ABDOMEN.—In the October 7, 1905, number of the *Journal of the American Medical Association* is an article on "Penetrating Wounds of the Abdomen," which was read in the section of surgery and anatomy of the American Medical Association at their fifty-sixth session, July, 1905, at Portland, Ore., by Prof. Randolph Winslow. Besides a general outline of the symptoms, complications, sequellæ, prognosis and treatment, the writer reports a series of 29 such traumatisms. Dr. Winslow emphasizes the importance of early operation, for in his series of 24 operative cases 15 recovered and nine died, while only one of the five unoperated cases recovered. Without operation 30 per cent. of patients died; with operation 62.5 per cent. recovered. In military practice Dr. Winslow believes in non-interference.

DRAINAGE AND SUPPURATIVE PERITONITIS.—Dr. I. R. Trimble, class of 1884, professor of anatomy and clinical surgery in the College of Physicians and Surgeons, Baltimore, at the clinical section on surgery and medicine, delivered an address on "Drainage and Suppurative Peritonitis," October 20, 1905, of which the following is the gist: "When we have to deal with septic conditions in the general peritoneal cavity endeavor to institute drainage from the lower abdominal segment, for the chances of recovery of the patient are thereby considerably enhanced. Moreover, by experience it has been proven in general suppurative peritonitis that the patient's chances of recovery are improved if he is kept in the upright or Fowler's position, so called from Dr. Fowler of Brooklyn, N. Y., who was the first to recognize the utility of this posture. Under no circumstances permit the patient to assume the recumbent position. If he is seen at his home and has to be removed to a hospital, order the attendants to be particular about maintaining their charge in a sitting posture. While waiting to be taken to the operating-room, be sure the sufferer is not permitted to lie down, so as to allow gravity to work. The *rationale* of this method is due to the fact that the pelvic cavity is more able to take care of pus than that part of the cavity above the pelvic brim. He reported a series of 10 cases of extensive peritonitis treated since early summer in this manner, of which nine recovered and one died, a percentage of 10 in deaths. His previous results, when his patients were permitted to lie in the supine position, will not compare very favorably with this record. Dr. Trimble lays emphasis on handling the intestines as little as possible, and by no means wipe the lymph from the bowels. He is inclined to believe the days of gauze drainage are numbered, for in a few days after insertion it clogs up with exudative material, so he has instituted in his cases either drainage with a rubber tube cut in a spiral manner or with a lamp chimney filled with gauze. In either case, when the drain is removed, there is not such a liability of denuding the bowels of the protective exudate, nor is there the same tendency to breaking up adhesions.

THE PRINCIPLES OF LIFE.—In an article teeming with interesting theories, entitled "The Principles of Life," in the *Journal of the American Medical Association* of September 9, 1905, Dr. Marshall Langton Price, class of 1902, secretary of the State Board of Health, endeavors to explain the phenomena of "Age" by advancing three dogmatic hypotheses, i. e., first, the failure of the cell is due to repeated inflammations, as a result of which it is replaced by a connected tissue cell which is incapable of performing the function of life; second, the death of the cell is brought about by a failure in nutrition; third, the destruction of the cell is due to its inability to resist and overcome pathologic processes.

As it is not the only condition connected with old age, the first theory is abandoned. Having rejected the first hypothesis, the author assumes the position that cessation of life can be explained by his two last theories, i. e., failure in nutrition of cells and the inability of the cells to resist pathological invasion. If life is dependent upon these laws, he concludes there must originally have been some constituent of the cell which had

the power of protecting the organism. This substance, hypothetical in nature, he calls bioplasmine.

According to the writer's reasoning, every cell must contain a substance necessary to its function, which as used is progressively exhausted, and when a certain stage of depletion is reached the organism perishes. He, moreover, maintains that this material when once used is never renewed, that the age and duration of a cell is dependent upon the amount of this evanescent principle with which it is endowed at an early period of life, i. e., previous to the morula stage of embryonic existence, as stated above, is called bioplasmine, and the writer conceives of it as a body analogous to a zymogen so like those organic ferments to be derived from a preliminary body called by him bioplasminogen. This latter constituent, he states, is formed by the union of the male and female elements during or shortly after the act of copulation, and is transformed into blasmine during the absorption of the morula mass, whence it is deposited in the cells of the organism, to be used when occasion demands. It is to the loss of this blasmine he attributes the phenomena of "Age."

Prof. J. Mason Hundley, at the meeting of the section on clinical surgery and medicine of the Medical and Chirurgical Faculty, October 20, 1905, delivered an address on "Conservative Operations on the Tubes and Ovaries in the Presence of Inflammatory Diseases." By conservative methods he means the conservation of a part of an ovary and tube or an entire ovary and tube whenever feasible. With this object in view he has endeavored to estimate the value of conservatism as practiced by himself upon 19 cases, so he appends the following results: Of his series so treated, eight were unimproved, seven improved and four cured. In two instances the remaining ovary had to be removed, and in one case pregnancy ensued before term; however, miscarriage resulted. He honestly believes that it is a legitimate line of work that is going to tell, but the gynecologists must have the support of the medical profession. It is nonsense to extirpate ovaries simply for pain, nor should they be removed because they appear inflamed, any more than the testicle is castrated under similar circumstances. He frankly admits it is not in his power to arbitrarily lay down hard and fast lines as to what ovaries shall be removed and what not, but declares conservative work is perfectly justifiable and feasible.

The oration at the January meeting of the General Alumni Association will be delivered by Dr. James Carroll, U. S. A., a most distinguished graduate of this school. He was one of the staff of doctors appointed by our government after the Spanish-American War to investigate the method of transmission of the yellow-fever contagion, and whose discovery of the mosquito as the means of conveying the disease made it possible to so successfully combat this dreaded malady at New Orleans this year. Dr. Carroll holds the chair of bacteriology in the Georgetown Medical School.

Dr. J. P. Young, class of 1894, of Richburg, S. C., where he is practicing his profession with much success, writes the BULLETIN as follows: "Enclosed please find my subscription to the BULLETIN for next year. I found great pleasure in scanning the copy recently sent me and heartily commend the undertaking. It can but be of material benefit to our old alma mater and is bound to be a great source of pleasure to all loyal alumni." It is a great pleasure to receive friendly and appreciative letters of this character from the alumni. It shows the right kind of spirit, and a spirit that every alumnus ought to feel for his old alma mater. It is to be hoped that Dr. Young's letter and others which have been published in preceding issues will be a further incentive to every alumnus to contribute to the support of the BULLETIN.

The Musical Association at the University of Maryland, which has prospered each year under the guiding spirit of Prof. J. C. Hemmeter, has recently organized with the following officers and members: President, P. A. Gamlau; vice-president, C. L. Ziegler; secretary, M. M. Cullinly; treasurer, Wm. Coleman; J. L. Anderson, R. O. Apple, T. A. Apple, W. D. Allsworth, W. F. Blakeslee, W. S. Burns, D. W. Creet, Wm. Dew, S. E. Douglas, P. H. Flood, T. A. Foley, F. A. Garland, W. S. Garland, Edw. Green, E. S. Green, G. H. Hiney, C. B. Homle, R. W. Jackman, F. B. Kehoe, J. M. King, R. M. Kinton, F. A. Lesley, E. S. May, D. J. McCann, J. A. Moran, H. B. Messmore, H. J. Noonan, J. N. Osburn, T. W. Pendexter, W. H. Perrin, D. C. Phan, A. T. Phifer, G. A. Phillip, A. P. Reade, A. P. Scarborough, T. Taylor, G. E. Truitt (Mexico), E. W. Wagner.

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EDITORIAL

THE CENTENNIAL OF THE UNIVERSITY.—At a recent meeting of the General Alumni Association of the University of Maryland its secretary-treasurer, Dr. E. F. Cordell, brought forward a number of suggestions looking to the celebration of the centennial in 1907. Among these suggestions Dr. Cordell urged the importance of an effort upon the part of the alumni and friends of the University to raise an endowment fund of $100,000. It is well known to the alumni how active and successful Dr. Cordell has been in raising the present endowment fund, which has grown annually under his zeal and persistent effort. Under discouragements which would have paralyzed the efforts of any other man, Dr. Cordell, single-handed and alone, has devoted his best energies to raising an endowment for the University, and has laid a foundation which will continue to grow under his untiring efforts. In the great undertaking which he now proposes the BULLETIN will render every assistance in its power. No one should cast cold water upon such sanguine hopes as he entertains, but every friend of the University should give encouragement and support to an undertaking which, whilst optimistic, is within the bounds of accomplishment. No one knows what can be done until the effort is made to raise this large sum of money. The BULLETIN believes that the occasion is one which will appeal in the strongest terms to the pride and generosity of the people of Maryland. The fact that this grand old institution of learning has been in active and continuous service in the cause of education in Maryland for 100 years should appeal to every unselfish citizen in this State. In addition, the thousands of alumni of its different departments, now scattered throughout the civilized world, should have a generous pride in the future of their old alma mater. Few people are wanting in pride and generosity when proper claims are made in behalf of worthy objects of benevolence or upon their patriotism. Has any institution in the State a stronger claim upon the pride and loyalty of its citizens than this old State University, which has trained more physicians, dentists and lawyers than any other institution in the South? Is not the past record of the University such a one as to justify the belief that her future is assured and that all that she needs is an endowment to place her upon a plane in keeping with the requirements of other State Universities?

The time has come when the narrow and critical spirit which has hedged in the University of Maryland should yield to larger and more generous views of her future possibilities. If her present government by a Board of Regents is not as alert and progressive as might be desired, there is every reason to hope that a large endowment will bring about methods of administration that will be highly favorable to the progress of the University and enlarge her scope of usefulness to the people of the State.

By force of circumstances the present system of separate management of the different departments has been made a necessity. Each faculty has been forced to maintain the work of its special department. Each department has prospered under these necessary conditions in the absence of an endowment; but it is fair to assume that larger results will come when a consolidation in management can be effected through a governing body with an endowment fund to provide the machinery for more profitable work.

The BULLETIN believes that the University has many influential friends who are proud of her record and hopeful of her future. It is only necessary to bring these friends in closer affiliation with the University and to arouse their interests in her behalf. The hope of raising a large endowment fund for the centennial is not Utopian if a strong and vigorous effort is made in that direction.

THE SESSION OF 1905-1906.—The present session at the University opened the first week in October with encouraging indications of large classes of students in all the departments. In the medical department, owing to a change in the educational requirements for the freshman class, it was believed that this class would be much smaller

than for some years past. Such has not been the case, as the class numbers about the same as last year. The senior class, from present indications, will be the largest in the history of the University.

In the dental and pharmaceutical departments there is an increase in number of students over last year. In the law department a slight increase is probable. In all of the departments over 800 men are now enrolled for the session of 1905-1906. This is, as far as we are aware, the largest student-body in attendance upon any institution in the State. In quality and character of material, as well as numbers, the University of Maryland is open to congratulation. The record for the year promises to be the most successful in her history.

CLASS REUNIONS.—In the last number of the BULLETIN attention was called to the importance of class reunions of the alumni of the University. It was stated that members of the class of 1881 proposed to celebrate the twenty-fifth anniversary during the year 1906. Of this class it is believed a large number will welcome the opportunity to meet again and revive the memories of student days. In the present faculty there are two members of this class, Dr. C. W. Mitchell and Dr. L. E. Neale, and these gentlemen will act as a committee in charge of the reunion. Members of the class interested in this reunion are requested to send their names to either of these gentlemen or to the BULLETIN, in order that a canvass may be made and steps taken looking to a proper celebration of the occasion.

POST-GRADUATE INSTRUCTION AT THE UNIVERSITY.—It may be proper to remind the alumni of the University that whilst there is no regularly-organized course for post-graduate instruction in connection with the educational work of the school, there are abundant opportunities for acquiring special training in the different branches at little expense. During the year a number of former graduates take advantage of these opportunities and receive instruction in the laboratories and hospital, which is very profitable to them. The BULLETIN would urge such of the alumni as may feel the need of a larger knowledge of subjects than they now have, to come back to the old University and rub up against the walls of the institution. Even a few days spent in the hospital or laboratory will be improving and stimulating. Many new facts and suggestions will come from a casual renewal of old associations. The older graduates will find great improvements in methods of work and will be pleased with the great progress which has been made since their student days. It is needless to say that the University extends a cordial invitation to all of the alumni to take advantage of any opportunities which may be presented for their pleasure or instruction. All are welcome to see and learn what is going on, and can feel assured that their old teachers and friends will extend to them every courtesy and consideration as well as cordial greetings.

THANKS TO OUR ALUMNI.—With each issue of the BULLETIN its promoters are greatly encouraged by words of approval and cordial support the alumni are extending to it. Not only are subscriptions coming in from all parts of the country, but frequent letters tell how kindly the BULLETIN is regarded by those who still retain an affection for the old University. These many evidences of approval of the course adopted by the BULLETIN furnish the very best argument in support of the work it has undertaken. Its policy of bringing old students in closer relations with their former classmates and of giving out monthly the latest news from the University is meeting with proper commendation, and will be continued so long as the material is at hand for publication. The BULLETIN is painfully aware of its many shortcomings and of unavoidable errors, but it promises to correct mistakes and to widen its sphere of usefulness if the alumni will contribute to its columns and to its support. It believes its field of usefulness can be greatly extended. As it grows in its financial returns it will increase its number of pages and will add new features that cannot fail to be of interest to every reader. Recognizing the value of the work of the University, it will continue to assert the claims which this old institution has upon the medical profession of this country and upon the loyalty of her alumni. The BULLETIN likewise recognizes the claims which the alumni have upon their alma mater and the helpful relations which should exist between the two. To promote the interests of both will be its highest endeavor.

Dr. A. B. Rees, class of 1900, is an interne of the Carney Hospital, South Boston, Mass. After leaving the University of Maryland the doctor took a degree in medicine from Harvard University.

NOTES AND ITEMS

Dr. S. W. Jones, class of 1894, lives at Franklin Falls, N. H.

Dr. R. H. Pate, class of 1898, is located at Unadilla, Ga.

Dr. Paul R. Brown, class of 1901, is practicing his profession at Guthrie, O. T.

Dr. William H. Davis, class of 1902, is located at Atlantic City, N. J.

Dr. Floyd O. Rogers, class of 1902, has recently settled at Newport, R. I.

Dr. William H. Baltzell, class of 1889, is spending the winter in India.

Dr. Thomas H. Buckler, class of 1888, is in Paris, France.

Prof. Randolph Winslow has been elected a consulting surgeon to the Hebrew Hospital.

Dr. R. Lee Hall, 1901, has been elected secretary of the Worcester County Medical Society.

Dr. Thomas H. Buckler, 1888, has been elected president of the New Paint and Powder Club.

Dr. Basil B. Brim, class of 1902, is practicing his profession with great success at West Toledo, Ohio.

Dr. C. V. Mace, class of 1897, is located at Rossville, Md., where he has built up a large practice.

Dr. F. E. Medina, one of our New England graduates of 1901, is located at Lowell, Mass., and is doing well.

Dr. Henry A. Cotton, class of 1899, is superintendent of the Danvers Insane Hospital, Hawthorne, Mass.

Dr. Josiah T. Payne, class of 1862, has moved from Corbett to Sunnybrook, Baltimore county, Maryland.

Dr. R. C. Carnal, 1905, of New York, now practicing at Rhemes, S. C., is spending a few days in Baltimore.

Dr. Benjamin R. Ridgeley, class of 1847, on September 20 celebrated the fiftieth anniversary of his wedding.

Dr. Alexander Ruiz Soler, class of 1906, has been elected president of the University Cuban Society, 1905-1906.

The fourth edition of Prof. David M. Culbreth's "Manual of Materia Medica and Pharmacology" is in press.

Dr. Josephus A. Wright, 1885, has been spending a few days in Baltimore visiting his son, Arthur Leon Wright, 1909.

Dr. John T. O'Mara, class of 1903, resident physician for three years at St. Agnes' Sanitarium, has resigned to take up other work.

Prof. Randolph Winslow has been elected chairman of the section of clinical medicine and surgery of the Medical and Chirurgical Faculty.

Dr. H. B. Stevenson, class of 1892, of Sherwood, Baltimore county, Maryland, recently sustained a fracture of his left ankle.

Dr. Daniel Base has declined a position in the department of pharmacology, hygiene laboratory of the public health and marine hospital service.

Dr. Taylor E. Darby, class of 1904, of Barnesville, Montgomery county, Maryland, is at Colon, Panama, in the governmental service as a physician.

Dr. Oliver Parker Penning has returned from a trip to Savannah, Ga., and New York, with his health greatly improved and benefited by the outing.

Dr. A. J. Cromwell, professor in the North Carolina Medical College, who recently visited the University of Maryland, we understand, has been offered a chair in Baylor University, Texas.

Dr. A. W. Valentine, 1904, who is located at 602 Pennsylvania ave., Washington, D. C., paid the University a flying visit November 7. He is always given a hearty welcome by his old friends.

Dr. B. B. Ranson, class of 1902, of East Orange, N. J.; Dr. N. G. Heggie, class of 1902, of Orlando, Fla., and Dr. H. P. Carter, class of 1903, of McKenney, Va., were among the recent visitors to the University Hospital.

Dr. Henry J. Lamontagne, class of 1906, who recently had his left leg amputated for osteosarcoma, expects shortly to leave the Hospital for his home in Connecticut. The BULLETIN wishes him a speedy recovery.

Dr. A. W. Graham, class of 1905, has been appointed assistant resident physician at Bayview Hospital, vice Dr. W. W. Riha, class of 1905, appointed assistant physician to Danvers Hospital for the Insane, Massachusetts.

Dr. William K. White, class of 1902, chief of clinic to the professor of gynecology, who was so ill during the summer with appendicitis, complicated with general suppurative peritonitis, has regained his former health and has resumed his professional duties.

Dr. John G. Jay, class of 1871, associate professor of clinical surgery, has returned from an extensive tour of the West. During his trip he visited the southwestern provinces of Canada, British Columbia, Seattle, Spokane, Portland, Yellowstone Park and other points of interest.

Dr. Joseph A. White, class of 1869, professor in the University College, Richmond, Va., after spending the greater part of his summer vacation in Europe, has returned to his home at Richmond and resumed his practice, limited to diseases of the eye, ear, throat and nose.

Dr. George B. Harrison, class of 1905, of Fredericksburg, Va., has received an appointment as resident physician of St. Luke's Hospital, Spokane, Wash. He reports for duty the early part of January. The BULLETIN extends its best wishes to him in his new field of labor.

The second session of the Library and Historical Society of the University of Maryland was held in Chemical Hall on Thursday, October 26, 1905. The following addresses were made: "The Ordering of Life," by Dr. Lewellys F. Barker; "Student Life at Old Oxford," Rev. Otto Huckel.

Contract Surgeon Calvin D. Snyder, 1898, United States army, recently stationed at Ambulong, Batangas, has been ordered to report to Binan, Lagune, Philippine Islands, for temporary duty; thence when relieved to Fort William McKinley, Rizal, for duty.

Dr. Eugene F. Cordell has been re-elected president, and Dr. Jose L. Hirsh, secretary, of the Library and Historical Society for the ensuing year. The next meeting will be held November 23, when addresses will be delivered by Dr. Henry E. Shepherd, on "Timrod and His Poems," and by Dr. Jose L. Hirsh, "Pasteur and His Works."

On October 7, 1905, at the University Hospital, Prof. St. Clair Spruill performed a rather remarkable operation in the form of skin-grafting. Nine men, without anæsthetic, submitted to the ordeal of sacrificing two strips of cuticle six inches long by one inch wide from their thighs, which were transferred to a scald wound extending from the thigh to the ankle of the patient.

On November 15, 1905, the twentieth anniversary of his doctorate, Prof. John C. Hemmeter was presented by his colleagues and former pupils, as a testimonial of their appreciation of his work, an oil portrait of himself executed by Mr. Louis Dieterich. Surgeon-General Walter Wyman, United States Public Health and Marine Hospital Service, delivered the presentation address in behalf of the subscribers.

Dr. W. G. Houseal, class of 1886, is located at Newberry, S. C., and is one of the most prominent physicians in his State. Dr. Houseal has recently delivered a course of lectures at Newberry College on the "Mosquito: Its Life, Habits and as a Cause of Disease," which shows his thorough familiarity with his subject and high scientific attainments. He is doing most excellent missionary work in a warfare for the extermination of the mosquito.

Dr. Joshua W. Hering, 1855, a most prominent citizen and banker of Westminster, Md., addressed the students of Western Maryland College November 5, 1905, upon the topic, "How Far May a Christian Participate in Party Politics?" According to the venerable doctor, Christianity does not prevent a man from engaging in politics. Political corruption is not due to bad men being in politics, but to good men holding themselves aloof from public office.

At the annual election of officers of the Senior Class, held October 31, 1905, the following card was elected: President, Victor C. Carroll, Maryland; vice-president, Manney Murdock Rice, South Carolina; secretary, Walter F. Sowers, Maryland; treasurer, FitzRandolph Winslow, Maryland; poet, Jorge del Toro, Porto Rico; historian, John Sterling Geatty, Maryland; valedictorian, Leo Karlinsky, Maryland; chairman of the executive committee, Arthur Blake Clarke, Canada.

Dr. John S. Fulton, professor of State medicine, presided at a public meeting November 2, 1905, at McCoy Hall, convened to consider the mosquito problem. On November 8, 1905, he delivered an address before the Montgomery County Medical Society at Kensington on Tuberculosis. Furthermore, on October 19, 1905, at the Second Hospital for the Insane, at Sykesville, Md., at the Carroll County Medical Society, he discussed the organization of Medical Boards of Health.

At the annual meeting of the Woman's Auxiliary Board of the University Hospital, held November 3, 1905, the following officers were elected for the ensuing year: President, Mrs. Hamilton Easter; vice-presidents, Mrs. Samuel Chew, Mrs. Joseph T. Smith, Mrs. William Howard, Mrs. L. B. Purnell, Mrs. Francis Waters, Mrs. Alcaeus Hooper, Miss Alice Chew, Mrs. William Paret, Mrs. Henry Matthews, Mrs. Sidney Turner, Mrs. John T. King, Miss Livesey; corresponding secretary, Miss Lucy Marshall; treasurer, Mrs. Hough; recording secretary, Mrs. Frederick Tyson.

MARRIAGES

Dr. Thomas Mears Green, 1900, Wilmington, N. C., a former assistant resident surgeon in the University Hospital and St. Joseph's Hospital, was married to Miss Emma Perrin West, Thursday, November 16, 1905.

Dr. Eugene H. Mullan, 1903, of the United States Public Health and Marine Hospital Service, formerly an assistant resident surgeon in the University Hospital, who was stationed in New Orleans during the recent yellow-fever epidemic, but now at Ellis Island, N. Y., was married to Miss Eleanor Virginia Gildea, 1905, a graduate of the University Training School for Nurses, November 4, 1905. The BULLETIN wishes the young couple all the happiness imaginable, as well as a long and prosperous married life.

DEATHS

Dr. John T. Keats (1858), at Baltimore, June 19, of heart disease, aged 70 years.

Dr. George Kalb, 1902, of Delta, Pa., aged 24, died November 3 of phthisis at the home of his parents at Catonsville, Md.

John Harrison Hunter, M.D. (1855), a veteran of the Mexican War and a surgeon in the Confederate service during the Civil War, died at his home in Berkeley Springs, W. Va., September 26, aged 76 years.

Dr. H. Blackburn Smith (1901) of Bermuda, British West Indies, during an epileptic attack fell down several flights of stairs and fractured his skull, from which accident he shortly afterwards succumbed.

Dr. Charles C. Shippen, 1879, aged 49, a member of the board of managers of the Charity Organization Society and chairman of its finance committee, died November 6, 1905, at his residence, 603 North Charles street, from a complication of diseases.

Members of the class of 1904 will deeply regret to hear of the demise of one of its most popular and genial members. We speak of R. M. Mann, 1904, of North Carolina, who died last month of phthisis, contracted during his fourth year's residence at the University. The BULLETIN extends to his father and to his brother Tom, both graduates of our alma mater, in the hour of their affliction its sincere sympathy.

Dr. George William Larrick, 1878, one of the most eminent physicians and surgeons of Frederick county, Virginia, died November 6, 1005, at his home at Middletown after an illness of two years, aged 53. For a number of years he was a member of the board of visitors to the Western State Hospital at Staunton, Va., and was also a Baltimore & Ohio Railroad physician. At one time he was a member of the Frederick County Board of Health.

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REPORT OF A CASE OF ACUTE SUPPURATIVE APPENDICITIS WITH METASTATIC HEPATIC ABSCESSES—POST-OPERATIVE EVACUATION OF A LIVER ABSCESS THROUGH THE LUNG—COMPLETE RECOVERY.

BY WILLIAM D. SCOTT, M.D.,

Chief of Genito-Urinary Clinic, University Hospital, Baltimore, Md.

The presentation of this case is prompted by the relative infrequency of this complication, and by the unusual vitality of the patient, even after the evacuation of a liver abscess through the lung, which was followed by a speedy convalescence and ultimate recovery.

Little of value can be added to the present voluminous literature upon appendicitis, yet a few remarks in regard to one of its rare and graver complications may be justified.

Frequency: Liver abscess associated with appendicitis, although early recognized in the history of the disease, cases having been reported by Waller in 1846, and Buhl in 1849, may be considered an unusual complication. Berthelim in 1895 collected twenty-eight cases. Loison in 1900 published one case, and considered the relative frequency of the association quite rare. Barenstreng collected a hundred new cases of liver abscess out of 7,326 autopsies in Berlin between 1859 and 1873, and found eight of these cases were a sequel to cæcal and appendical affections. Dudley found two cases of liver abscess due to the disease of the appendix, out of 28,034 patients at the Zurich Clinic between 1870 and 1891. Kobler in 1901 reported three cases of liver abscess, the result of appendicitis, from 17,204 autopsies at Vienna between 1881 and 1890, and ten cases of liver abscess out of 1,307 autopsies at Sarapcoa between 1894 and 1900, none of which were due to appendicitis. Jackson in 1899, recorded ten cases, the result of appendicitis, out of seventeen cases of liver abscess. Einhorn in 1901, from 18,000 autopsies at Munich between 1854 and 1899, found a hundred cases of peritonitis due to appendicitis, and in these, there were six cases of pylephlebitis and liver abscesses. Langheld in 1890, out of 112 autopsies, found four cases of pylephlebitis and two cases of liver abscess. Single cases have been reported by Krackowitzer (1891), Coluquhoum (1887), Jorand (1894), Skeen (1896), Trowbridge (1900), Dale (1901), Stooke (1901), and others.

Bacteriology.—The Bacteriology differs in no respect from that of appendicitis. Cultures from the abscesses and the portal vein within the liver show a variety of bacteria, as all of intestinal flora may present. As in appendicitis the bacillus coli communis is often found alone, or combined with the streptococcus or staphylococcus pyognes.

Etiology—The pathogenesis of these hepatic abscesses is clearly demonstrated, since the appendix veriformis has a rich lymphatic and blood supply. It is connected with the portal circulation by the appendical vein, which empties into the ileocecal branch of the superior mesenteric. The symtemic venous system likewise gives a moderate supply to the region of the appendix, and anastomosis is formed with branches of the portal venous system through the veins of Retzius.

The organisms causing the resulting abscess may reach the liver through the biliary, the lymphatic, the arterial, or the venous channels, or by extension from the peritoneum.

The biliary route is very rare, but cases have been recorded of abscesses of the bile ducts, originating from disease of the appendix, causing suppuration of the intrahepatic bile ducts. It is probable in these cases that disease somewhere in the portal venous system was responsible for the liver infection.

The hepatic artery may transmit septic material to the liver from the appendical abscess.

The lymphatics of the appendix, although not

[NOTE—The operation in this report was performed by Dr. St. Clair Spruill, whose assistant I was at that time.]

communicating with the liver, may indirectly cause this infection by connection being established with the parietal lymphatics through adhesions or a retroperitoneal abscess, or suppuration of the ileocecal lymphatic chain of glands may act as a nidus for portal infection.

Peritoneal extension causing liver abscess, sometimes accompanies supra or sub-hepatic collections of pus in suppurative appendicitis, infection occurring through continuity of tissue.

The portal system as an avenue of infection is the most constant route. Although, the pyogenic organisms may be carried from the appendix to the liver without causing disease of the venous trunk, however, the autopsy findings generally demonstrate a pylephlebitis due to the formation of septic thrombi in the vein. A single branch or the entire portal system may be affected and post-mortem examinations have revealed various degrees of inflammation of the venous walls, septic thrombi, or fluid pus in the portal, superior mesenteric and appendical veins.

Case—F. E. Age, 15. Single.

Occupation—Farm hand.

Family History—Good. One aunt died from phthisis.

Previous History—During childhood had measles, with no apparent complications. Patient says he "has had indigestion and some liver trouble all my life."

Present History—Two weeks ago patient woke in the morning with a severe pain in the abdomen —rather diffuse in character. Later it radiated to the region of the liver on right side, and to both shoulders. Pain was acute, stabbing, and worse on movement. Respiration on right side was extremely painful.

Physical Examination—Patient entered hospital November 6, 1904, complaining of pain in right lower chest and stomach.

Development—Very poorly developed. Complexion, sallow; entire body showed a distinct yellowish tinge.

Expression, anxious; features, pinched.

Eyes, conjunctivæ, normal in color. Pupils equal in size and react to light upon accommodation.

Temperature, 100 1-5; pulse, 88; respiration, 26. Mouth, mucous membrane normal in color and appearance. Tongue, protruded in median line and heavy white coating on dorsum. Tonsils, negative. Cervical glands, normal in size.

Chest, inspection, clavicular fossæ not indented. Costal angle about 100°. Over right lower thorax and abdomen pigmented areas due to counter irritation before admission. Expansion greater on the left side and least over right lower thorax. A slight bulging of right lower chest is apparent. Palpation, tactile fremitus equal on both sides. Percussion, note over left lung anteriorally is resonant. In left axilla from seventh interspace down note is flat. Posteriorly, note is resonant.

Right lung, anteriorally precussion is resonant. but dull throughout from seventh rib down. Palpation over this area is painful. Posteriorly, precussion note is resonant above, slightly dull below.

Auscultation, breath sounds over both lungs anteriorly are clear, distinct and very high pitched. Going down the left axilla the sounds become less distinct and only faintly heard. Vocal fremitus over this region is diminished. In the right axilla breath sounds are indistinct, and below seventh rib are very faintly heard. Vocal fremitus is likewise diminished here. Posteriorly, above, breath sounds are normal. Over both bases they are indistinct, especially over right base. Here on inspiration are heard fine crepitant and sub-crepitant rales. Voice sounds are diminished over both bases.

Heart—Apex beat rather diffuse in character and heard best in the fifth inner space inside the nipple line. First sound is loud and booming; second is short and snappy. Murmurs, negative. Second pulmonic sound is slightly accentuated.

Liver—Hepatic flatness begins at seventh inner space in the R. M. L., and in the sixth inner space in the mid-axillary line and extends about two fingers' breadth below the costal margin. Palpation over right hypochondriac area causes patient much pain. Abdomen, tense, tympanitic and rigid throughout. Rigidity more marked in the right upper quadrant. Palpation, painful, but most tenderness is elicited over the region of the gall bladder.

Miscroscopical examination; blood, Widal negative. Haemoglobin, 80%; erythrocytes, 5,700,000; leucocytes, 26,000. Stool, negative. Urinalysis, color very high. Reaction very acid. S. G., 1035. Albumin, positive. Sugar, negative. Sediment, few white and epithelial cells. Little mucous. Much amorphus urates. No casts.

History of Operation—On November 11, 1904, patient was put to sleep with ether. A short longitudical incision was made through the upper right rectus, the peritoneum opened and gall

bladder and ducts demonstrated. These were found to be normal. A dense, firm wall of adhesions was found to the right of incision, extending downward and backward, which completely walled off all viscera to the right of gall bladder. Wound was closed with interrupted silkworm gut, sutures and a small sterile gauze drain was left in its upper end. Patient was next turned on left side. An incision was made over, and the tenth rib resected from the point about one inch posterior to the mid-axillary line, to its cortilaginous attachment. The pleura was not incised, but was pushed up away from the wound, and the peritoneum was opened. After repeated insertions of the aspirating needle into the right lobe of the liver two abcesses were found—one about the size of an orange, the other the size of a walnut. Upon further examination a large post-cæcal appendicular abscess was entered. The appendix could not be found. This abscess was firmly and thoroughly walled off from the rest of the abdominal cavity. Its contents were evacuated and the cavity drained with iodoform gauze, as was the small liver abscess. The larger liver abscess was drained with rubber tubing, having iodoform gauze packed around the tube. Patient stood the operation without stimulation. Microscopical examination of the pus showed streptococci and colon bacilli in abundance.

Following the operation, patient showed gradual improvement until the seventh day, when he was seized with a sudden lancinating pain in the right chest, accompanied with intense suffocation. Face became cyanosed; respiration, 68; pulse (?). This condition was shortly followed by the expectoration of a great quantity of very foul-smelling pus. Prostration was extreme, and respiration could only be accomplished in the sitting posture.

Heroic stimulation was commenced and infusion of normal salt solution was given at frequent intervals. After the reaction from the onset of this complication, the boy rapidly improved and the pus expectorated gradually diminishing in amount.

On December 22, 1904, patient was discharged from hospital in excellent general physical condition. He had gained much in weight since admission. Incisions were almost healed, wounds being superficial and covered with healthy granulations. At this time he is entirely well.

ANORCHIDISM.

By S. B. Bond,

Clinical Professor of Genito-Urinary Surgery, University of Maryland.

The total absence of the testicles is not a common condition, and it is one which is very difficult to prove exists, even after the death of the individual. It can be easily proved that no testicles exist in the scrotum, but it is easy to see how undiscovered testicles, retained in the abdomen in an undeveloped condition, might escape the most painstaking search on account of their diminutive size. Most cases reported as cases of anorchidism cannot be accepted as such—in the sense that these organs were absolutely lacking. They can only be received as cases in which no testicles were found even in a rudimentary and undeveloped state. Such an individual is practically an anorchid, of course. It is more than probable that in every case there are somewhere little masses of tissue—the remains of what nature originally intended for these important structures. If this conception of the matter is correct, then it naturally follows that the total absence of testicles is a condition which does not occur and that all these cases come properly under the head of arrested development.

This arrest of the process of development may occur at any stage in the evolution of these organs, so that they may remain as they are in fœtal life, or they may complete their descent into the scrotum, or its arrest may occur while they are descending.

The physical peculiarities of the individual will depend in some degree upon at what stage the cessation of growth took place, for the perfect differentiation of sex is dependent in some way, not at present understood, upon the perfect evolution of these structures.

Recently I had an opportunity of examining a young man of twenty-two years of age. He was in good health, except that from time to time he suffered from attacks resembling epilepsy. He was well-nourished; six feet in height; rather narrow in the shoulders and chest, the latter being flattened; the hips were broad in comparison with his shoulders; the legs and thighs rounded and of the feminine type; pubic hair was not abundant, and the growth feminine in arrangement; the body and the facial hair was scanty, and the former fine in texture; the penis

was of fair size, the glands pointed and resembled that of a boy; by rectum the prostate felt about the normal size for his age; the inguinal rings were patulous on both sides, though there was no hernia; the scrotum appeared normal in every way except as to its contents; both testicles were present, but they were merely little fibrous-feeling masses about the size of a small bean, the right being a little larger than the left; the cords could easily be traced down to these little bodies; there were no varicosities on either side; pressure on the testicles produced the usual sickening pain.

The history gave no clue to the cause of the abnormality. As a child the young man had the usual diseases, including mumps in one parotid, but there had been no metastasis; there was no history of injury; the nervous attacks began when he was about eighteen, and afterward occurred at irregular intervals.

Mentally he was apparently of average calibre; as a boy he associated with other boys by choice, and there was no indication that he would not grow up in every way like his fellows; the other sex has had no attraction for him at any time, and has not now; he has never had any sexual desire, and when asked concerning such things he does not appear to have a clear understanding of what is meant; having no sexual appetite, he has not attempted intercourse; erections occur, he says, once in six weeks, perhaps, but he does not seem quite clear about it or to know exactly what is meant, giving one the impression of wishing to appear to know more than he actually knows.

Curling reports a case of arrested development very similar to this one; his, however, came to post-mortem when the individual was forty-six years of age. Both testicles were in the scrotum, but they had undergone an arrest of development in early childhood and had remained infantile in every respect.

These cases are interesting from a general rather than from a special standpoint. Why the evolution of these organs ceases in an otherwise healthy boy is entirely unknown, and we have no rational treatment for the condition. In the present instance the fact was noted that frequent examination resulted in an apparent increase in the size of the testicles, so that it was natural to suggest a course of massage, with the hope that increased blood supply would stimulate growth. About two months after beginning this treatment the young man reported that there had been some gain, but I have not had an opportunity of verifying his favorable account, and I am inclined to think that his wish to be normal, at least in appearance, may have deceived him.

He made no mention of any aroused sexual desire, so I presume he continues without sexual life, not missing that which he never had.

CONCERNING SCIATICA.

BY A. K. BOND, M.D. (CLASS 1892), OF BALTIMORE.

Clinically sciatica is distributable into two classes: The congestions and the inflammations, the neuralgia and the neuritic. The former may take kindly to pressure on the nerve, the latter strongly resents it. The practical test is the quick response to remedies or the obstinacy to all treatment, and the presence of various paræsthesias in the neuritic class.

When caused by the influenza poison the distinction is not easily made, since, as in the lungs and other parts, a congestion lasting many days and yielding every evidence of inflammation may suddenly disappear, to be reproduced, perhaps, in other nerves. The extreme obstinacy of these influenzal congestions to remedies aimed at the nervous system is due, I think, to the fact that the congestion depends upon stercoremia, and will only yield when the latter is relieved. The evidence of the stercoremia in marked cases is that the breath, clothing and whole body have the same offensive and quite unique odor which the stools of severe influenza possess, or rather possessed very remarkably when influenza was pandemic a few years ago. In those days it often filled the whole sickroom, making an impression on the practitioner never to be forgotten.

The immediate occasion of sciatica is apparently an exposure of the body to cold. I say "apparently," because it is very difficult in some cases to exclude the possibility that the alleged chilling was a blood-septic manifestation due to the influenza poisons—the influenza patient often complaining of sudden chilling in a perfectly warm room, or even under blankets in a warm bed. In many cases, however, the sciatica immediately follows the careless leaving off of accustomed underclothing on a cold day, and then must be ascribed to the chilling. I suspect that a cold watercloset seat may sometimes cause a sciatica, especially when a cold draught plays from beneath (as it sometimes does in winter)

on the sensitive skin. Another possible cause is lying at night in a cold room on a mattress which is made permeable by air from beneath. A blanket placed next the mattress is an easy remedy for this chilling, and the patient at once appreciates the added comfort.

The treatment of the sciatica is really the important point for our discussion. I have been very much humiliated at times by the obstinacy of my cases, but have never yet had one in which it lasted year-long and left the marks of severe illness on the patient's face and whole appearance.

I think by proper care we may usually have the patient up and at his duties in a few days—at the most, weeks—although a recurrent ache or overfatigue or exposure to chilling reminds him unpleasantly that he has a sick and sensitive nerve to care for. The habits, however, of the patient, his obedience to orders, the nursing he receives, and his pre-existing chronic diseases will very much affect the prognosis.

The first thing of all in the treatment of sciatica (especially in those cases where external cold chills and exacerbates) is the application of heat with the protection of the skin from chilling. This is best secured, not by flannels, nor by sheet wadding, nor by hot water bag, nor by plasters, but by enveloping the whole nerve region—the whole limb from iliac crest to foot— in raw cotton laid directly on the skin. I order the nurse to buy a twenty-cent roll of cotton batting (that which is sold in rolls of colored tissue paper, but not the cheap brittle stuff sold in small stores), and unfolding it carefully into a fluffy sheet an inch thick, baste it into the inside of the drawers or into a legging made of cheesecloth. This is to be worn day and night until the nerve is quite well, or even until winter is over. Its advantage over flannel is that it lies more closely to the limb, excluding cold air, is readily renewed when soiled, and may be picked thin as the limb convalesces or as warm weather approaches. I regard this as my greatest safeguard against relapse, as well as my best healing agency. From time to time a hot water bag laid against the cotton is helpful, or the ironing of the part with a hot flatiron.

As sciatica is so often an end-result of stercoremia, through poisoning of the blood supplied to the nerve, disturbance of the arterial tension and blood circulation by foul matters in the blood, and disorder of the kidney secretion by these same foul matters excreted, I always begin my treatment by a thorough clearing out of the intestinal tract. A freshly compounded pill of the formula followed by our Sharp & Dohme in their Vegetable Cathartic No. 1, and also by Parke Davis, Upjohn and others, is very efficient, with the hundred and twentieth of a grain of strychnia to prevent its exhausting action (on some persons). Senna tea and castor oil are equally efficient, though very disagreeable. Milder aperients are mere delusions, except in rarely sensitive patients.

The pain of sciatica may be relieved either by Fraser's Compound Phenacetine Tablet, powdered or whole. It may be improvised from phenacetin, 2 grs.; antipyrin, 2 grs.; citrate of caffein, 1 gr., and milk sugar); or by powders of sodium salicylat, 15 grs.; sodi bicarbonate, 10 grs.; taken dissolved in water or in a syrup of ginger. Either of these agents may be given every four hours till pain is relieved, or they may be alternated, the salicylate two hours after the Compound Phenacetin Tablet. If the salicylate causes ear-ringing it should be stopped for a while and then given in half doses. I have never seen the Compound Phenacetin Tablet cause any heart or lung embarrassment. It should not be given near to sweet spirits of nitre—which makes, I believe, a dangerous combination with antipyrin.

Occasionally I give codeine sulphate in grain or half-grain doses. I use sometimes several preparations of the coal tar derivatives until I find an efficient one. Morphia I avoid as long as possible, for it acts imperfectly in pains of digestive septic origin and harmfully disorders the digestive processes in many patients. At times, Merck's colchicine is very soothing (1 grain to 1 ounce of alcohol—dose, 5 drops t. i. d.). At other times I have found ammonium muriate the best remedy, in ten grain doses every four hours. In favorable cases it relieves aching, tones up the body and acts as a cholagogue.

Sciatica is a whimsical disease, yielding in one case to a remedy that in the next case has no effect. Even in the same case remedies lose their power and must be replaced by others at first of no value.

Electricity (galvanic) is of exceeding usefulness. Applied alone (either pole), or with chloroform on the positive pole, it often gives delightful relief from pain, lasting several hours; and this may be repeated throughout the disease. Wet cupping is, I think, of very fleeting influ-

ence. Blistering produces sometimes sores more painful than, and nearly as persistent, as the sciatica, probably because of the poor nutrition of the inflamed skin. In later stages painting the limb with tincture of iodine is beneficial. Occasionally splints may be of value, but I do not, as a rule, use them; as the cramped position of the limb is very distressing (theoretically, they ought to do good). Slight elevation of the limb above the body level is necessary in severe cases.

In obstinate cases, I pay great attention to the kidneys, using various calmatives and diuretics. Bicarbonate of soda is sometimes useful as an antacid. Sweet spirits of nitre, citrate of potash, abundance of drinking water between meals, often tend to diuresis and relief of pain. Later in the disease I use strong tonics—iron, arsenic, strychnine, quinine. If salicylates in solution disagree, the salicylate of quinine is a good substitute—five grains in pill. Later it may be incorporated in the tonic pill. I doubt if I can report results of value from belladonna or potassium iodide.

Occupation of mind, fresh air, sunshine, wholesome, dry housing, extra feeding (three simple but abundant meals and three light lunches) are all of the greatest importance. Mental fatigue, as from long visits of friends, may cause relapses. The patient should be taught that a severely inflamed sciatic nerve can no more be hurried to its cure than a pneumonia. Yet medical care aids greatly in the cure and gives the patient great comfort. The mere securing of good sleep is worth the doctor's visits. I know nothing of nerve-stretching and the like; for my patients have convalesced nicely when they have obeyed orders. Occasionally, the "sciatica" is not in the sciatic nerve, but in adjacent nerves, but the principles of treatment are the same.

Hip-joint disease, uterine displacements, hysterical hyperesthesias may cause symptoms like simple sciatica. The distinction from such troubles is given in the text books. The patient should be warned that the convalescent nerve must be protected for a long time, and that in wet weather it—like any other feeble part—will probably complain. Tincture of iron or Basham's mixture is perhaps the best therapeutic safeguard against relapses.

Finally, the wise man will take care of his sciatic nerves, dressing properly and at once taking measures to restore their health if they begin to show distress. This is better than cure, for sciatica may wreck one's happiness, perhaps, for life.

PRESENTATION OF OIL PORTRAIT OF HIMSELF TO PROF. JOHN C. HEMMETER BY HIS FRIENDS, WITH ADDRESSES MADE ON THAT OCCASION.

On November 15, at his residence in this city, an oil portrait of Prof. John C. Hemmeter was presented to him by his colleagues and former pupils. The committee in charge were: Drs. Warner Holt, of Washington, D. C.; J. C. McAfee, of Macon, Ga., and Carl Nelson Brandt, of Hot Springs, Va. The occasion marked the twentieth anniversary of the doctorate of Prof. Hemmeter. A number of physicians and friends from Baltimore and other cities assembled at Prof. Hemmeter's residence, where the exercises were conducted, followed by a collation.

The BULLETIN is fortunate in being able to publish these addresses in full. The presentation address was made by Surgeon-General Walter Wyman, of the United States Marine Hospital Service, as follows:

Dr. Hemmeter:

I deem myself fortunate in having been selected by your friends to present to you this fine portrait in oil, commemorative of the twentieth anniversary of your doctorate.

These occasions are all too rare, when the intellectual and emotional parts of our nature are brought out together—the intellectual in the background and the foreground filled with expressions from the heart.

It is a delight occasionally to throw aside all thought of professional cares and official duties and give free exercise to our more natural sentiments of friendship and good fellowship. Too often the doctor is considered but a human being somewhat set apart from the rest of mankind and devoted solely to his science. This in my early days was drilled into me as to what a doctor should be. I resented it then, and now as one of the elders I feel free to protest against it. There is nothing in the medical profession which can claim from its devotees a sundering of those ties which bind all human beings in their social relations; nothing that should prevent the exercise of civic duties and an interest in all sciences, literature and art.

These are the ideas which are prompted by your own personality, for you have demonstrated in your life the great truth that a man may be a great physician, yet eminent in other walks of life, meeting the social demands of his nature, loving melody, and cultivating to a high degree a love of the beautiful and good as well as the true. Therefore, appreciation of intellect and appreciation of broad manhood alike have prompted this testimonial to you from your friends.

For your professional achievements we have the highest appreciation, and in this we are not alone. Eminent authorities in this and other lands have spoken eloquently of your published works; authorities and clinicians of international repute, as Ewald and Boas, von Leiden of Berlin, and Nothnagel of Vienna, have spoken for us, and rank the results of your work among those of classical medical scholarship.

With these few words, I present you in behalf of your friends this life-size portrait of yourself, in the prime of manhood; and as you and others look upon it, you and they will see not only the form of manhood, the impress of thought and character in the face, but in the frame which surrounds it there will be seen leaves of ivy signifying triumphs in science and art, and faces of friends beaming with pleasure on one who has endeared himself to his friends by his noble qualities of head and heart.

Dr. Warner Holt, chairman of the committee, made the following remarks:

Dr. Hemmeter:

It has been a great pleasure to the committee, and especially myself, to have been able to participate in the work of this evening, and to unite in one expression the sentiments of your many professional admirers throughout the United States.

It has been our effort to gather in this testimonial, not only your own former and post-graduate pupils, but representative clinicians in other cities; and made no appeal to your confreres in Baltimore, except when a request to that effect was received. We in other cities look upon this testimonial as an indication that the University of Maryland has taken a position among the leading institutions of medical learning in the country (being free from that bias which may develop from too close a sectional attrition), having produced such leaders in medical research as Councilman, A. C. Abbott, William T. Howard, Jr., Hemmeter, and many others, and has had at all times some of the most effective clinicians and surgeons in its faculty.

The fame of the Alma Mater is inseparably connected with and even depends upon the character of the work of its alumni. And in this connection we delight in the words which Nothnagel wrote to the publishers of Dr. Hemmeter's works: "They are the products of a master clinician—an inspiring teacher—an ornament to American medicine."

Apropos to this event, it would seem a graceful act to make some reference, in a general way, to the influence of the University of Maryland on American medicine.

The University of Maryland was founded in 1807—an epoch-making period in American history. The lights and fires in this temple of learning have modestly illumined the shadowland of medicine and blazed the path, throughout her successful career, with wise conservatism in policy and educational methods. The history of every science attests conclusions having been revised and re-revised to more nearly correspond with realities. In fine, the progress of knowledge consists in marshaling Thoughts into harmony with Things.

In this respect the University of Maryland has often been first—and always among the first—in the adoption of measures and methods in medical instruction, presaging the most fruitful results, as contributory factors in the process of high medical culture. She can point with pardonable pride to the many illustrious names among her alumni who have graced American medicine and surgery with emulable distinction and enduring lustre.

It seems as each expiring savant let slip the lighted torch from tired hands to become a star of destiny in the Æsculapian constellation, another valorous votary seized the heritage and bore it aloft in this unbroken column of truth-seekers. To-day, you will find them on the teaching staffs and in the laboratories of numerous medical institutions, delving in the mine of experimental facts—bacteriologic and biochemic—which submerge us, assaying the true from the false and minting them into accepted truths fit for the architecture of constructive medicine, dedicated to the physical and mental betterment of mankind.

This University, in common with other great medical institutions, has, no doubt, her quota of

alumni who have, like Atalanta, stooped to take up the golden apples, thus inhibiting the race in the prosecution and progress of medical science. It would indeed be difficult to measure and estimate the lasting impress and far reaching results made by the University of Maryland on American medicine. The achievements of her sons in the past and in the present form her obelisk. Her alumni are men who not only make history, but who are history. You will not find their names in "The Hall of Fame for Great Americans," as no scientist, physician, or surgeon has been impaneled therein. Their Hall of Fame is in the hearts of the American people. The world is influenced by the dead as well as by the living. In the language of Darwin—"Our lives are but a bundle of consequences; our present is but the outcome of the past." 'Tis here, on this occasion, that Past and Present touch—the nuptial of night and noon; the memorial in marble saluting the panegyric in painting.

CORRESPONDENCE.

TRAVELING IN ALASKA.

To the Hospital Bulletin:

The international boundary line between American and British territory is crossed at Dixon Entrance, and sailing in smooth waters, between innumerable islands, we soon reach the town of Ketchikan, with a population of 1,200 to 1,500. This place is the centre of the mining industries at the southern end of Alaska, and is quite a busy mart. It is a picturesquely situated town, the houses being built on piles on the water front, or perched on the steep hillside. Some of the cottages are quite pretentious, but most of them are small and dilapidated looking. There are no horses in Ketchikan, and the streets are narrow and paved with boards.

There are ore mills, salmon canneries and lumber mills located here, and I was surprised at the large and well stocked stores. Many small craft were moored at the wharves and three steamboats were present at the same time. The people were well dressed and orderly. I saw four doctors' signs, one dentist's and several lawyers, which would indicate that professional interests were well looked after. The houses were surrounded by yards and gardens, in which flowers grew luxuriantly, and vegetables, such as peas, potatoes, and raspberries, and many others, seemed to thrive well. All these little Alaskan cities are lighted with electricity, which shines out brilliantly at night from the dark background of mountains. A small precipitous mountain stream comes tumbling down the rocks at Ketchikan, and at the time of our visit salmon by the thousands were jumping up these falls striving to reach the more placid water above. Some of these salmon would be dashed against the rocks and killed, but many of them succeeded in surmounting the cataracts, and reached the pond above, where they were seen in incredible numbers, and also in the shallow rivulets farther on. Some of the passengers caught several of these fish, two feet in length, in their hands, and could have caught more had they been so inclined. The Indians spear them with pronged instruments.

At Ketchikan is a small hospital in connection with an Episcopal Church—St. John's, I think. The hospital appeared to be devoid of patients at the time of my visit, but was clean and comfortable looking, as viewed through a window. On the door of the church was posted an invitation "to walk in, rest, and pray."

Leaving Ketchikan, we proceed up Clarence Strait to Wrangel, situated at the mouth of the Stickine river, which leads into British Columbia. Wrangel was an old Russian military post, and the somewhat extensive log buildings are still in existence, and are used as government offices at this time. The town is beautifully situated, has, perhaps, 1,000 inhabitants, with some good buildings and residences, is lighted with electricity and has churches, schools, and fair hotels. Among other evidences of civilization is a brewery, by means of which the thirst of these far Northern fellow-citizens may be quenched. There is quite a settlement of Indians here, some of whom live in good houses, but most of them occupy huts. The Indians, to my mind, resemble the Japanese; the young women and girls are quite comely, but the old squaws are hideous. The men work in the mills and canneries, while the women and girls sit on the wharves and streets selling curios. It was noticeable that the natives wore American shoes, or went barefooted, but sold mocassins to travelers.

Wrangel is a good place to get furs and skins, but one has to be on the alert or he will get the small end of the bargain. The health of the town appears to be entrusted to two rival practitioners —one a homeopathic physician, and the other an apothecary. Neither of these gentlemen thought

much of the qualifications of the other. One of them supplemented his medical work by doing a little mining on Sunday. A government surveying boat was in port, and one of our crew and a sailor from the other boat had a lively set-to on the wharf, with bad results to the U. S. man, and twenty days in jail for our champion. We saw here many of the curious totem poles which are so characteristic of this part of Alaska. These totems are not idols to be worshipped, but are coats of arms or insignia of clans, by means of which a person is able to obtain refreshment and assistance in case of need.

The tide has considerable ebb and flow in these waters, and when it passes through narrow stretches navigation is dangerous and wrecks occur. We had, therefore, at several places to wait for the tide to change in order to pass safely through these difficult straits. In one place where it was too deep to anchor, and too dark to see the shores, the ship was obliged to judge its position by frequent blowing of the whistle and listening to the echo.

Passing the Wrangel Narrows, we come to several settlements, where large canneries or mills are established, and soon we are in the region of the glaciers. Some glaciers move down the mountains and discharge into the sea, and these are known as live glaciers, whilst others stop short in the cleft of the hills, and are called dead glaciers. We saw examples of each kind, the Taku glacier being a large live body of ice, from which icebergs are being constantly let loose.

From Wrangel to Juneau is quite a stretch through waters dotted with small icebergs even in the middle of summer, and adding somewhat to the danger of the passage. When in the neighborhood of the glaciers and bergs there is a decided lowering of the temperature, and overcoats become useful. Juneau is quite a nice city of possibly 2,500 inhabitants, situated on Gustineau channel, which separates it from Douglass City and Treadwell, or Douglass Island. The courthouse at Juneau is a fine structure, and there are several churches, including a Greek church, two hospitals—St. Ann's, a Roman Catholic institution, with a capacity of fifty to sixty patients, very fairly equipped and doing a beneficent work for twenty years, and the private sanitarium of an ambitious physician. We saw several cases of appendicitis, as well as of typhoid fever, convalescing. There had been quite a number of cases of typhoid at Juneau, the origin of which was obscure, as the water supply comes from the top of snowclad mountains, and apparently free from possibility of contamination. My traveling companion, Dr. Boucher, of Hartford, Conn., and I were most hospitably entertained by Dr. L. O. Sloane, of Juneau, a young physician of exceptional merit. The Mine Owners' and Operators' Club will compare favorably with those of many much larger cities.

Across the channel from Juneau is Douglass City, a smaller town, but with considerable population, and in immediate proximity Treadwell, where the extensive gold mines are situated. At the Palm Garden restaurant in Douglass City I was surprised at the excellent accommodations, and enjoyed most heartily as good a dinner as I wish to sit down to. The Treadwell mines and works are very extensive, and in 1904 the chief mine distributed $900,000 to the stockholders. This is a gold quartz of low grade, but of such enormous quantities that it is very profitable. Shafts are sunk in the rock 1350 feet, and the ore is blasted out and conveyed to the surface to the stamp mills, where it is crushed and the gold extracted. Through the courtesy of Mr. Kinzie, superintendent, and Mr. Stowe, assistant superintendent, we were taken down into the bowels of the earth 900 feet and permitted to see the process of mining, and then conducted through the enormous mills, where the din is such that conversation is impossible. Eight hundred men are employed at these works and mines. There is a hospital for the employes, and a surgeon who receives $1 per man monthly. The works are run continuously, day and night, the only holidays being Christmas, Washington's Birthday and the Fourth of July.

We reached these parts on Sunday and were enlivened by the arrival of a large local steamboat filled with excursionists, who had spent the day on the water or at some resort. A fair brass band discoursed music, among which "Dixie" and "Maryland, My Maryland," was rendered. It certainly turned my thoughts several thousand miles in another direction.

On July 24 we were sailing up the beautiful Lynn Canal, making stops at Eagle River and Fort W. H. Seward. The latter is a fine United States military post, where the headquarters and three companies of the Third Infantry are stationed, and which looked to be a very comfortable place to spend a term of service, if not too long.

Skaguay is situated at the head of Lynn Canal, and is the northern terminus of our trip. This is a straggling town, on level ground, between lofty mountains. It has four long wharves, up which rattling 'buses are driven, bearing the familiar name of Fifth Avenue Hotel and others equally pretentious. The hotels are fairly good, and the town was a place of much importance before the completion of the railroad over the White Pass, but now it is very much sidetracked, as passengers for the interior are at once conveyed over the mountains by rail, and do not have to outfit at this place. There were some nice houses and stores, many small cottages and cabins and some log cabins, but the general appearance of the place was that of decadence. In many yards flowers were growing in profusion, and vegetables were also thriving in the gardens. The weather was hot, the thermometer standing at 84°.

I saw some very typical sights here, amongst them a two-seated carriage drawn by four dogs, and conveying a portly man and woman and child, at a lively gait. We made the trip to the summit of White Pass, a distance of 22½ miles to the international boundary line, on the White Pass and Yukon River R. R. This is one of the steepest ascents in the world, an elevation of 3,000 feet being attained in twenty-two miles. The scenery is most picturesque, as the road in some places is on the edge of a canyon a thousand feet deep. At the summit the American and British flags fly side by side, as the boundary line traverses the tops of the mountains.

RANDOLPH WINSLOW.

THE REPORT OF THE WOMAN'S AUXILIARY BOARD OF THE UNIVERSITY HOSPITAL OF MARYLAND FOR THE YEAR ENDING NOVEMBER 1, 1905.

To the Faculty:

The Woman's Auxiliary Board of the University Hospital of Maryland desire to submit to the members of the Faculty the report of its work for the last year, from November 1, 1904, to November 1, 1905.

At the outset of the year the Woman's Auxiliary Board set before itself as its chief work the building and paying for the porches of the Greene street wing, at a cost of $3,280.00.

This result has been very nearly accomplished, for at the closing of their fiscal year, November 3d, 1905, $3,050.00 have been paid, leaving a balance of but $225.00, with every prospect that the near future will see that entirely liquidated.

The treasurer's report shows that $3,444.77 have been deposited by her to the credit of the Board. The monthly committees have contributed in money $627.80. Adding these two sums together, we have the result that the Board has given the last year to the Hospital the sum of $4,072.57.

The monthly committees have been active and faithful, and have, in addition, made large contributions of blankets, linen, clothing, etc. They have sent fruits and flowers in large quantities, never failing a single week. Orders were left by different members that ice cream and other dainties should be given the patients, where, in the judgment of the superintendent, it was desirable to do so. A sitting-room for the women and a play-room for the children has been fitted and made comfortable with lounges and rocking-chairs for the grown-ups, and toys for the children. A recovery ward was furnished throughout as a memorial by a member—Mrs. Levering.

Some members of the Board have visited the Hospital every week of the year, nor have they ever gone empty-handed; while, with words of comfort and consolation, they have striven to lighten, if even by a little, the load of suffering around them, often administering to the needs of the patients after they have left the wards of the Hospital.

Dinners have been given to the free wards on Thanksgiving Day, Christmas, Easter and the Fourth of July. Entertainments of music, recitations, etc., have been provided and greatly appreciated by the patients.

At the Christmas festival a tree was provided for the children, and the wards were decorated in the hope that thus a little of the Christmas joy might be brought into the dull lives of the inmates.

The Board strives as much as possible to meet the needs of the superintendent of nurses, and with that end in view has placed a medical chart cabinet in the private halls; dryers have been placed on all the new porches in order that the unsightly view of clothing and bedding, drying all along the bannister, may be avoided. The china closet of the private halls has been daintily replenished, and many new and beautiful articles placed in the private rooms.

Books, periodicals and magazines have been

placed through the wards, and the beginning of a permanent library has been started.

A matter in which the Board has taken a very keen interest has been the paving with wooden blocks of Greene street. The noise of constantly passing carts was so deafening and the distress of the patients so great that the Board determined to put forth every effort to have the matter remedied. To that end every member of the Council was visited, and members of the Board appeared before the Committees on Highways and Estimates. Their arduous efforts have been crowned with success, and a pavement such as is desired is to be placed early in the year while the Committee on Highways gave the ladies the gratifying assurance that their action was due to the representation and assiduous work of the Board.

Such has been some of the things accomplished by the Auxiliary Board within the year, which it ventures to bring to the notice of the Faculty, hoping for its interest therein.

In conclusion, the Women of the Auxiliary Board would express their desire to aid the Faculty in every way within their power, and to join with the Faculty in every object having for its end the welfare and prosperity of the Hospital, which is so dear to all and every member of the Board. FLORENCE MACINTYRE TYSON.

LIBRARY AND HISTORICAL ASSOCIATION.

At a meeting of the Library and Historical Association of the University of Maryland, held November 23, 1905, in Chemical Hall, the following programme was rendered:

(a) Timrod, the South Carolina Poet,
Prof. Henry E. Shepherd.

(b) Pasteur and His Works,
Prof. Jose E. Hirsh.

Louis D. Pasteur, physicist, chemist, bacteriologist and scientist, born on the 27th day of December, 1822; died September 28, 1895, aged 73 years; the son of a poor tanner; began his education in the village school, but books had no attraction for him, hunting and fishing being more to his taste. At an early age he developed a fondness and talent for drawing. In 1847 he graduated from the Normal School in Paris, taking the degree of D. Sc., his ruling passion now, and not diminishing with age, being the pursuit of the study of chemistry.

In 1857, having noticed under the microscope that the solid mass formed in the process of lactic acid fermentation was composed of numerous rod-like bacteria, he brought forward his vitalistic theory, *i. e.*, organisms are a prerequisite for fermentative action. In 1862, for an essay which conclusively proved that organic life cannot arise by spontaneous generation, he was awarded a prize by the Academy of Science. During the same year he delivered an address to the vinegar manufacturers of Orleans, and demonstrated that the mycoderma aceti produced the mass on the top of the fermenting liquid. In 1870 the French Government selected this eminent scientist to study the etiology of the epidemic of pebrine, an affection which was ruining the silkworm culture of France. He not only discovered the cause to be due to a special organism, but he also outlined an entirely satisfactory course of treatment. Lister's work in antiseptic and aseptic surgery is entirely dependent upon Pasteur's researches and labors. At the age of 55 we find him devoting himself to the pathological phenomena of anthrax. Koch and other investigators had already cultivated and seen the anthrax organism, but they did not recognize the relationship existing between the malignant pustule and the organisms.

It remained for Pasteur to not only definitely determine the cause, but also to institute a practical system of preventive vaccination, namely, the inoculation of the healthy animals with attenuated cultures of anthrax organisms; a mild septicemia ensues, but, as a rule, stock so treated acquire an artificial immunity to future attacks. By the introduction of this simple measure much expense was saved to the cattle raisers of France. We next find him devoting his energies to rabies, one of the maladies most dreaded by physicians, and almost universally fatal. The treatment of Joseph Meister, the boy who was bitten by a rabid dog, with inoculations of an emulsion from the dried bits of the spinal cord of rabbits killed by hydrophobia, marks a glorious epoch in the alleviation of suffering. In 1895 this man, who had done so much to alleviate human ills, died of paralysis. He was given a public and military funeral, and laid to rest in the Pasteur Institute, a monument to his scientific researches. Pasteur was a member of many societies, both foreign and domestic, and had been decorated by most of the European governments.

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EDITORIAL

ALUMNI ASSOCIATIONS OF THE UNIVERSITY.

With the exception of the Alumni Association of the Medical Department of the University of Maryland, located in this city, we know of only one other association of the Medical Department of Alumni in active operation. This latter association is located in Washington, D. C., and has an active and loyal membership of some thirty graduates of the University—men who represent the very best element in the profession of that city and who reflect honor upon their Alma Mater. The good work, the unselfish devotion and the high aim which the Washington Alumni have in view is flattering alike to them and to the University. They have shown a loyal and affectionate regard for the institution which has honored them with a degree in medicine, and their example should be an inspiration to all of the Alumni of the University wherever found. The man who neglects or forgets the mother who gave him birth is on a par with the graduate who forgets his duty to the school which trained him for his life's work. We believe there are comparitively few men who belong to this class. The majority of men are simply wanting in demonstration because they are separated from the object of their attachment, or weaned by time and distance from relations which call forth their loyalty and affections. The only way to bring these old graduates back to their early attachments is to go after them, to come in relation with them in some way. In the past the University has been too indifferent towards her children. Her children in the most natural way have oftentimes resented this indifference. The BULLETIN hopes to be the medium of reconciliation and to bring about more affectionate relations between the child and the mother. Various methods may be employed to restore the good fellowship which should exist, but we know of no method that has a more practical value than the one employed by the Alumni in Washington. These Alumni have an organization. They meet once a year around the banquet table, and drink to the health of each other and to their Alma Mater. They cherish memories of student days, and recall the past as they push forward to the future. Good fellows for the time being, their friendships and relations continue from year to year as they follow their professional work in the same community. No doubt they are helpful to each other and are individually profited by holding on to one common interest—a loyal devotion to the old University.

The University has a large number of Alumni all over the South. In some of the smaller cities as many as half a dozen or more can be found practicing side by side, and perhaps in many instances ignorant of the fact that they have interests in common—the same Alma Mater. Why, then, not organize local Alumni Associations and meet occasionally around the banquet table? Such meetings cannot be otherwise than profitable. The BULLETIN hopes to see the Alumni in North and South Carolina especially, where the University has so many children, organize State Alumni Associations. Will not some of our graduates start such a movement? The Medical Department stands ready to aid in such a movement, and will no doubt give consideration to the claims which the local Alumni in any State or community may make in furtherance of their interests.

WHAT THE UNIVERSITY OF MARYLAND STANDS FOR.

A well known physician, not a graduate of the University of Maryland, but a warm friend and admirer of the school, in a recent letter to the editor of the BULLETIN has this to say:

"There is an atmosphere of aristocracy mantling that venerable institution which as an inherent endowment far exceeds, to me, the acquired endowment of similar institutions. It is to be devoutly wished that the Commonwealth may pay substantial homage to such an institution." This tribute to the character and dignity of the University is not exaggerated. If any student

of educational history will take pains to examine the records of the University during the past seventy-five or eighty years, he will be impressed with the fact that this school has at all times been loyal to the very best traditions and standards in educational work. The men who have filled her chairs and guided her policies have been gentlemen of the highest moral and social position, men of dignity, honor and professional ability. They have kept before them high ideals of professional ethics, a just appreciation of the manliness and nobility of professional work and the highest regard for sound, conservative and correct standards of teaching. In all of her history the University has stood for character and merit. She has aimed to give her students the very best equipment in practical knowledge and in moral tone. The atmosphere around the institution has been pure, wholesome and invigorating. Her graduates, with rare exceptions, have established her reputation in the communities in which they have labored and borne fruit, which bears testimony to the vigor of the soil in which they were first trained for professional work.

A UNION OF THE MEDICAL SCHOOLS OF BALTIMORE.

It has been suggested by more than one of the representatives of the three leading medical schools of Baltimore that a union of the University of Maryland, College of Physicians and Surgeons and Baltimore Medical College, under one corporate body would give this city one of the largest and most influential medical schools in this country and so strengthen the cause of medical education as to make the movement a popular one throughout the United States. The advantages of such a union are so striking that little can be said against it, except as relates to the equitable disposition of the property interests held by each school. Mergers of corporate bodies are so common at the present day that no unusual difficulties should arise in organizing a holding body to take over these respective institutions, and to conduct them along lines that would be advantageous to all interests now concerned in the government of each school.

It is not our purpose to offer plans, but simply to suggest the expediency of such a movement, and to invite attention to the many advantages which could be made to flow from a closer union of the representative schools in our city.

If in union there is strength, it also follows that harmony, singleness of purpose and efficiency of work will result from a combination in which the elements are raised to a higher plane of organized effort. The cause of education would not only be advanced and strengthened, but economies of administration would bring larger profits to both teacher and student. It is not probable that a merger of the character suggested would bring about radical changes at once. There would be no need for disturbances of any of the teaching bodies except as suggested by time and expediency. Vacancies in the corps of teachers being inevitable, consolidation and merging of chairs would come in a natural way and thus strengthen the entire body. Laboratories with better equipments would concentrate the work of instruction and do away with the present multiplication of poorly equipped laboratory rooms. Methods of instruction now employed would be reduced to a single system, whilst the requirements of the graduate would apply alike to a large student body and raise the standard to a uniform plane.

In administration, business methods would reduce the expense of registration, of advertising and of clerical work, so that all fixed charges could be based upon accurate estimates. The combined classes of these schools herein referred to now number between 1100 and 1200 students in attendance upon each session. The merging of this large student body under one corporate management would exercise a powerful influence in drawing larger classes and in the selection of better material.

The time may not be fully ripe for the organization of such a movement as is here suggested, but to those who observe the rapid changes which have taken place in recent years in the improvement of medical instruction, it is apparent that the day is not remote when such results will follow.

ABSTRACTS AND EXTRACTS.

THE PATHOLOGY OF ETIOLOGY OF HUMAN VACCINIA.

In the November 11th issue of *American Medicine,* Dr. William Travis Howard, Jr., 1889, Professor of Pathology, Western Reserve University, Cleveland, Ohio, has an article on the "Pathology and Etiology of Human Vaccinia." His conclusions are based upon a series of three simultaneous vaccinations on the left arm of thirty

men, of which twelve were successful. From these, as well as three of the unsuccessful endeavors as controls, varying from 48-168 hours after the vaccinations, portions of the skin were excised and stained, in most instances with esoin and methylene blue. Microscopically the skin lesion was found to closely resemble that of variola, viz., the formation of a vesicle, with destruction of the epidermis. The bleb consisted of a recticulated structure, whose spaces contained fluid, granular material and a few cells. The earliest changes observed were swelling of the epidermis, hyaline degeneration of the cells, the invasion of one epithelial cell by another, and a marked nuclear degeneration. Later, the nucleus, shrivelled, condensed and fragmented, was dispersed into the cytoplasm and intercellular substance. The above enumerated changes were seen in sections removed both from the lateral margins and base of the pock. In the corium the changes were intense, edema, hemorrhage, leucocytic infiltration of the tissues, and a proliferation of the endothelium of the lymph and blood vessels being observed. After 72 hours the changes in the lesion are of degree only, *i. e.*, an intensification of the above-described transformations. After 120 hours the epidermis begins to regenerate, the process of throwing off the crust, however, taking some days. No bacteria have been isolated from the lesions of vaccinia, and there is a complete absence of pyogenic organisms, but structures corresponding to the cellular bodies described by Councilman, class of 1878, were found in the 48 and 72-hour lesions, there being a complete absence of inter-nuclear parasites. These organisms the writer considers as the etiologic factor in the production of vaccinia.

The process of vesiculation is completed in 48 hours, not four days, as commonly believed, for at this period the vesicle is filled with leucocytes, and scab formation has begun. Indeed, the lesion is a well-established pustule. In variola the virus reaches the skin through the circulatory system, consequently the changes spread outward, while in vaccinia the degenerative process is from without inward. The author believes the degenerative and inflammatory changes to be due to a soluble toxin, and immunity is intimately connected with the dispersion of this poisonous substance. The lesions are hypothetically explained by the invasion of the epithelial cells lying between the horny and malpighian layers with organisms, causing a degeneration and necrosis of the cells and reticular formation. With the segmentation of the parasites and their escape from the cells, it is supposed a soluble toxin is discharged into the lesion. It is this toxin which causes the widespread degeneration and necrosis. With the formation of the secondary vesicles local immunity is apparently established. Dr. Howard thinks the asexual cycle of the cytoryctes variola is completed in 48 hours, and that the process of immunity production continues for several days after the formation of the vesicle. In summing up his conclusions especial emphasis is laid upon these phases of the vaccinia processes: (1) In human vaccinia vesiculation is well established by the end of the second day; (2) The changes in the epidermis correspond closely to those of variola; (3) The extra nuclear stage of cytoryctes variola occurs in human vaccinia; (4) If the bodies described by Councilman and other pathologists are parasites, there are certain animals which have the property of inhibiting the development of the sexual cycle, but permit that of the asexual cycle, which is pathogenic in most animals, and gives rise to an immunity in man which protects against both cycles.

NOTES AND ITEMS

Dr. Oak S. Gribble, 1904, is located at Beverly, West Virginia.

Dr. Arthur Edward Ewens, 1904, is located at 1512 Pacific avenue, Atlantic City, New Jersey.

Dr. T. O. Heatwole, 1897, at the November election was elected to the Maryland House of Delegates.

Dr. William Winder Goldsborough, 1901, of Greensboro, Maryland, has been elected a member of the State Senate.

The engagement of Dr. Cooper R. Drewry, 1902, of Mineola, Virginia, to Miss Mary Tasker James, has recently been announced.

Professor Eugene F. Cordell, 1868, delivered an address before the Historical Section of the College of Physicians of Philadelphia on November 29.

Dr. Willis B. Fitch, 1902, of Moores, Clinton county, New York, has sufficiently recovered his health as to be able to resume the practice of medicine.

Medical Inspector Howard E. Ames, 1874, was

summoned to Annapolis to testify in the Meriwether case, and was present at the autopsy upon the body of Cadet Branch.

On November 16, 1905, Dr. Page Edmunds, 1898, delivered an address before the Baltimore County Medical Society on an irregular case of impacted stone in the lower ureter.

Dr. Beverly W. Briscoe, 1903, of Pocohontas, Somerset county, Pennsylvania, last month paid a flying visit to Baltimore. He reports that he has been eminently successful in his practice.

Dr. John Mace, class of 1887, of Cambridge, Maryland, has been commissioned a lieutenant in the Maryland Naval Reserves and is detailed to act as surgeon of the Cambridge division.

Dr. A. E. Ledbetter, 1888, of Greensboro, North Carolina, is taking a post-graduate course at the University. Dr. Ledbetter formerly held the office of county superintendent of health.

Dr. Henry McKee Tucker, 1889, a former assistant resident physician at the University Hospital, but now located at Raleigh, North Carolina, stopped in Baltimore to see his old friends recently while on a trip to Philadelphia and New York.

Dr. Robert Waldorf Fisher, of the class of 1903, is located at Morgantown, West Virginia. Dr. Fisher was assistant resident gynecologist in the University Hospital, 1903-'04. He is doing well in his present location and has acquired quite a large and lucrative practice.

Dr. Charles Caspari, Jr., dean of the department of pharmacy, has been elected an active member of the University of Maryland Medical Association, as a mark of appreciation of his labor and interest in the welfare of the University and as a slight token of esteem for his ability as an author.

Dr. John C. Hemmeter, professor of physiology in the University, and Mrs. Hemmeter, were guests of the Washington, D. C., Branch of the Alumni Association on the evening of the 23d ult. A number of the members brought their wives to meet Mrs. Hemmeter, and the doctor was good enough to make some appropriate remarks on a "Greater University." Among those present, of the Association, were Drs. Cook, Cole, Bishop, Bowen, Hurt, Morris, Malone, Belt, Fry, Keech, Lewis, Richardson, Nichols, Shands and Stone, and Surgeon General Wyman.

Dr. Eugene Lee Crutchfield, of the class of 1887, residing at 1221 E. Preston street, Baltimore, Maryland, who has been so ill with a traumatic peritonitis, incurred by perforating the bowel and letting loose a large quantity of sterile sulphocarbolate of zinc solution in the peritoneal cavity, while passing an irrigating tube through an appendicostomy opening for the purpose of irrigating an ulcerative colitis and proctitis, has so far recovered as to be able to resume the practice of his profession. The appendicostomy was performed by Dr. Samuel T. Earle, class of 1870, at St. Joseph's Hospital, Baltimore, Maryland.

Before the nose and throat clinic of the University, November 16, 1905, Mr. J. T. Umpley, of New York, demonstrated the use of ethyl chloride as a general anesthetic. Its use is chiefly limited to operations of short duration, where unconsciousness of three or four minutes is required, for tiding over labor pains, and forceps deliveries. It also finds a useful field in the induction of insensibility preliminary to ether anesthesia, thus obviating the disagreeable features of the primary stage of the latter anesthetic. The chief advantage of its employment over ethyl bromide is its lesser mortality. In a series of 200,000 cases not a single death being recorded, whereas in ethyl bromide administration one out of every 50,000 cases succumbs. Over nitrous oxide its superiority is attributed to the inexpensiveness of the apparatus, any snugly fitting ether cone made moderately airtight answering the purpose.

Our dear, beloved friend and benefactor, Gen. Ferdinand C. Latrobe, the president of the Board of State Aid and Charities, has again made his annual attack upon the justice of the State's contribution to the support of our University. According to his usual custom, he will recommend to the Legislature the inadvisability of an appropriation of any sort be made to the medical colleges of Baltimore, Hopkins excepted, castigating them as private corporations. Of course the heavily endowed Hopkins University ought to be aided, if for no other reason than "to him that hath shall be given, but to him that hath not shall be taken away all that he hath." It behooves our Alumni who are members of the General Assembly to counteract any tendency

upon the part of their fellow associates to withdraw their influence from the medical colleges, and to advocate as formerly a spirit of generosity to our schools.

MARRIAGES

Elisha Lewis Sencindiver, M.D., 1891, was married to Miss Mary Flick Stewart, at Martinsburg, West Virginia, on November 15, 1905.

Dr. S. Baskin Sherard, 1905, of Ira, South Carolina, was married Tuesday, December 5, 1905, to Miss Mattie Moson, of Newark, New Jersey.

Dr. Norman Ellis Sartorius, 1904, of Tangier, Virginia, was married November 15, 1905, at Pocomoke City, Maryland, to Miss Ella Frances Schoolfield.

At Cooksville, Howard county, November 29, 1905, Miss Elsie Ann Shipley, only daughter of Dr. Luke M. Shipley, 1869, was married to Mr. Wesley Sewell Frizzell.

Dr. John Walker, 1891, of Lynchburg, Virginia, was married November 29, 1905, to Miss Laura May Stebbins, daughter of Hon. Joseph Stebbins, of South Boston, Virginia.

Dr. Philemon Smith Lansdale, 1902, son of Dr. B. Frank Lansdale, 1866, of Damascus, Maryland, was united in wedlock November 29, 1905, to Miss Annie Pyle, of Charlottesville, Virginia.

Dr. Harry Gibbons Utley, of Apex, North Carolina, a former resident obstetrician of the University Hospital, was married November 25, 1905, to Miss Florence Jennings Percival, of Baltimore, Maryland.

Dr. Herbert Lee Kneisley, class of 1905, of Westminster, Maryland, was married November 9, 1905, at Hagerstown, Maryland, to Miss Daisy Sophia Bester. Among the ushers were Drs. W. A. Parvis, W. J. Riddick, Harry E. Jenkins, classmates of the groom.

Dr. John Charles Macgill, class of 1891, son of Dr. Charles G. W. Macgill, 1856, and grandson of Dr. Charles Macgill, 1828, of Catonsville, Maryland, was married in the early part of November to Miss Annie Campbell Gordon Thomas, stepdaughter of ex-Governor Whyte.

Miss Katherine Atkinson, daughter of Emeritus Professor I. E. Atkinson, and sister of Clinical Professor A. Duvall Atkinson, was married to Mr. John Clarke Rice, of Boston, Massachusetts, during the early part of December, at the home of her father, 609 Cathedral street, Baltimore, Maryland.

Dr. Frank O. Miller, 1902, Alberton, Maryland, was married in the early part of November to Miss Bertie H. Penning. Dr. Miller was formerly an assistant resident physician at Bayview Asylum, and one of the members of the board of editors of the college annual, *Bones, Molars and Briefs,* while a student.

DEATHS

Charles Edward Deaver, M.D., 1891, a member of the Massachusetts Medical Society, and of the Lynn Medical Society, died at his home in Lynn, Massachusetts, October 24, 1905, from cerebral hemorrhage, aged 43.

As the BULLETIN goes to press, the deaths of Emeritus Prof. George W. Miltenberger, class o 1840, and of Dr. P. H. Reiche, class of 1869, are announced. In the next number full notices of these distinguished Alumni will be given.

Dr. Joseph Veazey Wallace, class of 1853, one of the oldest physicians in Cecil county, died at Lewes, Delaware, November 16, 1905. Dr. Wallace for over forty years practiced his profession at Chesapeake City, and for a number of years took an active part in Democratic politics of Cecil county. He was seventy-three years old.

Dr. Christopher Fawcett, class of 1864, for fifty years a resident of Northwest Baltimore, and most of that time connected with the Union Protestant Infirmary, died at his home, 550 Mosher street, November 11, 1905, from a complication of diseases, in the 82d year of his age. Dr. Fawcett was best known through his connection with the Union Protestant Infirmary, of which he was superintendent and resident physician for thirty-nine years, which positions he resigned in 1891, having had, since 1864, a continuous connection with this institution, with the exception of a short period in 1865, when he served as an assistant surgeon in the Federal Army.

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PRESENT STATUS OF THE EDEBOHL OPERATION FOR NEPHRITIS.

BY ARTHUR M. SHIPLEY, M.D.,
Medical Superintendent University Hospital.

The surgical treatment of various kidney conditions, spoken of as nephritis, is a subject at present very much under discussion. It is very difficult to arrive at any definite conclusion as to just what the present status is, as the operation is such a recent one that few men have operated for nephritis a sufficient number of times to enable them to give any very full report.

Just how renal decapsulation brings about a cure of chronic nephritis is a very difficult thing to understand. It is claimed that after decapsulation, free anastomosis is established between the denuded kidney surface and surrounding parts. If this actually occurs we can understand how the benefit is brought about. Yet Thorndike found after experimentation that animals in whom the kidneys had been decapsulated, had no appreciable collateral circulation, but that the kidneys were surrounded by a new and firm scar tissue capsule. It is highly probable that a fair per cent. of the cures reported have been cases in which movable kidney complicated the nephritis, or was a causative agent in the production of the symptoms that lead to a diagnosis of nephritis. It is a noticeable thing in reading reports already published that those patients in whom there were marked evidences of advanced Bright's at operation are often the cases either dying immediately after operation or at a time not far removed from the surgical interference. It is just possible that some of the benefit attributed to surgery may be due to the regulation of the patient's habits and diet which is brought about by the operation. It is a well-known clinical fact that life can be very much prolonged in persons suffering from Bright's if careful attention be paid to these two most important factors—diet and hygiene. Yet the weight of reported cases certainly is sufficient to make the subject worthy of trial and discussion.

Edebohl has reported most excellent results. Reports by other men are not so sanguine. There is one condition often confounded with nephritis which is almost always benefited or cured by decapsulation—this is the so-called essential renal hematuria. This condition may be easily taken for nephritis, as there is present in the urine not only blood, but often casts and albumen as well. Whether the bleeding be due to pressure or not, we are unable to say, but this we do know, that essential renal hematuria is very often cured by decapsulation. Now it is a well-known fact that often a diagnosis of chronic nephritis is made on too slight grounds. Because a patient has in his urine albumen and casts is not sufficient grounds always for a diagnosis of chronic Bright's disease, and it is easily possible that some of the so-called cured cases belong to this class.

Edebohl has reported seventy-two cases. Of these seventy-two, seven died immediately following operation from various causes, chief among which was a continuation of the nephritis. Nine cases reported as improved, were critically ill at time of operation and, as far as symptoms are able to show, were within a few days or weeks at most from death. Several of these cases were waterlogged, partially unconscious and partially blind. Of this number—seventy-two—twenty-two died at a time more remote from operation; thirteen of this twenty-two died of Bright's; of this thirteen, only six reported as unimproved; three are classed as unimproved, twenty are reported as decidedly improved, seventeen are reported as cured.

Now if we can be sure that all of these seventy-two cases were really chronic Bright's, then this report of twenty cases decidedly improved and seventeen cases cured, brings the entire question of surgical interference in nephritis squarely before us. Unfortunately, this operation in the hands of other surgeons has not given the same brilliant results. It is far too early to say just what posi-

tion in surgery this procedure will take. We cannot help but remember that all along the history of surgery the way is strewn with discarded operations that once held a brilliant sway—more or less brief—and we cannot but be apprehensive. It is devoutly to be wished that this operation will take its place among the curative surgical procedures. It would be tremendously hopeful and cheering to thousands of persons condemned to a death none the less sure because its progress is slow.

When we take into consideration the changes in kidney structure brought about by chronic nephritis, it is difficult to understand how decapsulation is going to cure the condition. The weight of authority points clearly toward marked temporary improvement, but to say that the condition is cured, seems a rank statement, made on too insufficient evidence. A major operation is by no means an ideal thing for a patient suffering with Bright's, yet Edebohl has said, with truth, "that when medical science of the future shall have found some simpler, more readily and generally applicable, safer and equally sufficient treatment—let us say cure—for chronic Bright's disease, then will renal decapsulation become a memory and a matter of history."

In view of the fatality of chronic Bright's, and its tremendous prevalence, together with our almost utter helplessness in treating it medically, and our utter helplessness to effect a cure, any measure that looks toward improvement in this almost helpless condition should be accepted with joy. Also it is very inimical to progress to condemn a measure which has not been thoroughly tried, especially when the weight of good authority is in its favor.

It would seem from the reported cases that chronic interstitial Bright's with contracted kidneys and tremendous increase in the connective tissue, with consequent pressure on the tubules, with a dense adherent fibrous capsule, are the cases most benefited by decapsulation. Chronic parenchymatous nephritis is not so often improved.

Of the several cases operated on here, all of them showed the most tremendous improvement. In each case the secretion of urine was tremendously increased just after operation. It is probably a long way to the last word regarding the general bearing of this operation on the treatment of Bright's. Let us earnestly hope that it will do all and even more than is claimed for it. The practice of medicine is fraught enough at best with pathological conditions, in the face of whose progress toward the destruction of life we are absolutely powerless, and any aid, no matter in what unlikely guise it may come, should we welcomed and given thorough and fair trial.

PREGNANCY IN ASSOCIATION WITH UTERINE FIBROIDS.

By Hugh W. Brent, M.D.,

Late Resident Gynecologist, University Hospital, Baltimore, Md.

This paper is a brief study of three cases of pregnancy complicated by fibro-myoma uteri operated on by Prof. T. A. Ashby in the University Hospital.

It may be well to preface the history of these cases with a few words on this interesting subject.

Pregnancy is, of course, relatively more likely to occur as we approach the normal in the uterus, tubes and ovaries. Organic disturbances in either or all of these important organs influence to a great degree the proper fertilization and development of the ovum.

The uterus with a normally developed, healthy endometrium and musculature, one in which the elements essential to the retention and nourishment of the ovum have not been impaired, is the one in which we expect pregnancy to go to term without complication.

Pregnancy is unlikely to occur in the fibroid uterus, the frequency depending, of course, to a great extent on the size and situation of the tumor.

Thus we would least expect to find it in association with submucous growths, entailing degenerative changes in the endometrium and accompanied by more or less constant hemorrhage.

In the subperitoneal variety the changes in the mucosa and uterine cavity being in many cases comparatively slight, conception and development are not so markedly influenced.

The differential diagnosis between simple pregnancy and simple fibroid is in itself at times extremely difficult and much more difficult is the diagnosis of the two conditions when coincident; in many instances absolutely impossible, without thorough exploration of the uterine cavity. If the diagnosis is definitely settled without recourse to this last measure, the question arises: will the woman go on to delivery of a viable foetus, or is the case one for operative procedure of some kind.

Unquestionably hysterectomy has been performed in many of these conditions, where expectant treatment would have resulted in the birth of a living child.

On the other hand, we know that abortion is very frequent, sepsis and hemorrhage more likely, and retention of secundines a complication of no mean importance in the distorted uterine cavity. Difficult and protracted labor at term, with possible fatal result to mother and child, is not to be forgotten.

Every case must be judged on its own merits, the gynecologist relying on the behavior of the growth before pregnancy, its size and situation and the present disturbances resulting from it.

In the case of pedunculated subperitoneal tumors giving rise to pressure symptoms, a myomectomy may be done; if the growth is to any great extent interstitial, this should not be attempted. Myomectomy is at best a serious operation and the chances of sepsis and hemorrhage are much increased in the vascular pregnant uterus. If the uterus is incarcerated in the pelvis by a growth in the posterior wall or by an impacted, prolapsed, pedunculated tumor, the mere release of the uterus by pulling it and the tumor up over the pelvic brim, may allow pregnancy to proceed to term with no untoward complication.

If there is general fibroid development—especially if the gestation is limited to a horn of the distorted uterine cavity, a supravaginal hysterectomy is the operation of choice.

The gynecologist may be called after labor has begun and find it impossible to deliver in the presence of the existing tumor, a porro-Cæsarian section is advisable. If it be recognized at first that delivery will be prolonged or extremely difficult, this may be the operation of choice.

The three following cases illustrate two classes:

In case 1 the uterus was the seat of multiple fibroids; interstitial, submucous and subperitoneal. Pregnancy had occurred in a horn far up on the anterior wall and abortion was impending. Supravaginal hysterectomy was done.

In case 2 a large pedunculated tumor about the size of a small watermelon was found attached to the fundus uteri by a pedicle five c.m. broad and two c.m. thick. Myomectomy was done, and the woman went to term and was delivered of a living child.

Case 3 is in all respects similar to Case 1.

Case 1.—Mrs. P., age 32 years; patient of Dr. Cronk, Woodbine, Md. Primipara.

Patient has been married about six months and has not menstruated for past four months. The abdominal enlargement has been out of all proportion to normal gestation. At present time patient has the appearance of a woman at term. Uterus has developed rapidly and fills the entire pelvis and much of the abdominal cavity. Examinations reveal pregnancy in association with multiple fibroids. The pelvis is blocked by a fibroid mass giving rise to distressing pressure symptoms—pain, vesical irritability, partial obstruction of the rectum with painful and difficult defecation—there has been no uterine hemorrhage since conception.

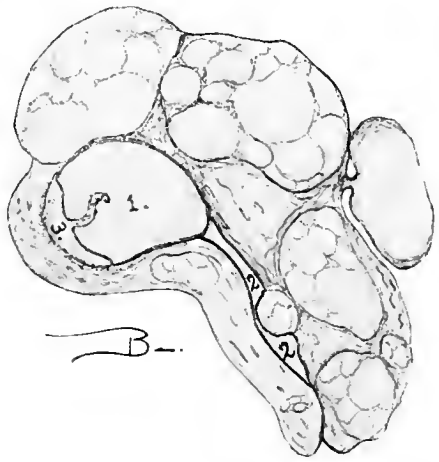


FIG 1.

Operation was advised, and a supravaginal hystero-myomectomy done; the pregnancy was about four and a half months advanced, the uterus filled with multiple fibroids. The patient made an uninterrupted recovery and left the hospital cured in three weeks.

Case 2.—Mrs. B.; age 32 years; primpara—patient conceived in November, 1904, and was admitted six weeks later, suffering with frequent urination, painful and difficult defecation and general abdominal pain and discomfort. She had missed her last two menstrual periods.

Examination revealed an enormous tumor filling the pelvis and abdominal cavity and crowding the pregnant uterus downward. The abdomen was nearly the size of full term. A laparotomy was done, and a large pedunculated myoma removed by an easy myomectomy.

Patient left the hospital cured three week later. In July she was delivered, without trouble, of a full term child.

Case 3.—E. C., negress; ii. para; age 35 years; pregnant four and a half months. This case was

in every respect similar to Case 1; same treatment, same result.

In all three of these cases there had been no sign or symptom of fibroid in the uterus prior to conception. During pregnancy there had been no uterine hemorrhage. All patients applied for relief from pressure due to rapid growth of the tumor under the stimulus of pregnancy.

IN MEMORY OF

PROFESSOR GEORGE WARNER MILTENBERGER.

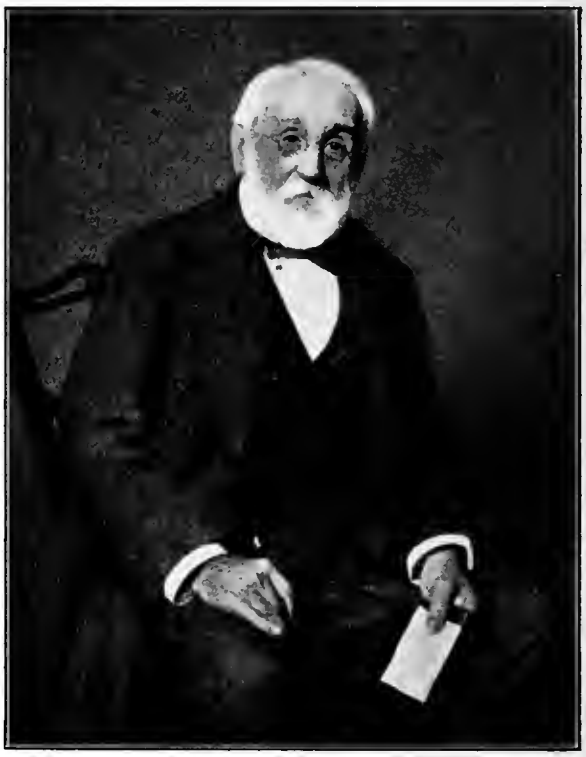
By S. C. Chew, M.D.,

Professor of the Principles and Practice of Medicine, University of Maryland.

The School of Medicine of the University of Maryland is now within one year of completing the century of its existence, and throughout that period it has been in continuous and uninterrupted operation. It is a notable fact that for sixty-seven years, more than two-thirds of the time of its duration, from 1838, the year of his first matriculation, to 1905, the year of his death, Dr. George W. Miltenberger was connected with this school in the several relations of pupil, instructor, active and emeritus professor and honorary president of its faculty, without any vacant period in his successive advances from the first of these positions to the last. It would probably not be easy to exemplify such a long alliance in the history of any other institution of learning in this country.

From an early period of his life, George Miltenberger was characterized by an eager desire for the acquisition of knowledge. The first rudiments of his education were acquired at the Boisseau Academy in Baltimore, at which many prominent Baltimoreans laid the foundations of their subsequent attainments. Among his schoolmates at this institution was the late Severn Teackle Wallis, who was his senior by about two years and a half, and from the starting point both of them were destined to reach eminence in their respective professions and in the University of Maryland—Mr. Wallis as its provost and Dr. Miltenberger in its medical faculty. The present writer was once told by Mr. Wallis that "Little George" (as Miltenberger was affectionately called by his fellow pupils) was distinguished among them as an intelligent boy, quick at learning and always pleasant in manners and neat in appearance.

On leaving the Boisseau Academy, he continued his studies preparatory to his future work in life at the University of Virginia, and on completing his course there he began his professional curriculum in the University of Maryland, at which he took the degree of doctor of medicine in 1840.



PROFESSOR GEORGE WARNER MILTENBERGER

His diligence and attainments as a student there are witnessed by the fact that almost immediately after his graduation he was appointed to the position of demonstrator of anatomy in 1840, than which no stronger evidence could be given of the esteem in which he was held by his teachers. To the duties of this post were added, in 1847, those of lecturer on pathological anatomy, and it is believed that in making this appointment, the University of Maryland was one of the first schools in this country to establish this as a distinct branch of teaching.

At this time Dr. Miltenberger became also one of the visiting surgeons at the Hospital of the University of Maryland—then known as the Baltimore Infirmary—a position which has for many years been traditionally associated with that of demonstrator of anatomy, and which afforded

then, as it does now, abundant opportunities for acquiring pathological knowledge and technical skill. Two years subsequently he was appointed one of the attending physicians to the Baltimore City and County Almshouse, and in these two fields—the Infirmary and the Almshouse—he found constant occasions, of which he industriously availed himself, for work in medicine, surgery, obstetrics and pathological anatomy.

In 1852, on the advancement of Prof. Samuel Chew to the chair of practice of medicine in the University of Maryland, Dr. Miltenberger was appointed to that of materia medica and therapeutics, continuing also in this new position to give instruction in pathology.

In 1858, Professor Richard H. Thomas, on account of failing health, resigned the chair of obstetrics, which he had held since 1847, and Professor Miltenberger was at once appointed to the vacant place and occupied it with increasing distinction as a lecturer and teacher for the long period of thirty-two years, until 1890, or nearly twice the length of time during which he had been an instructor in the various other branches of medicine and surgery. It was thus, as a teacher of obstetrics, that he was most widely known among the alumni of the School of Medicine in the University of Maryland, having given instruction to many more students in that branch than in any other.

If, however, a special characteristic is sought for as belonging to Dr. Miltenberger it is to be found in the remarkable versatility of his attainments, both as a teacher and a practitioner. It has, perhaps, not often happened in the history of any school that one man was so competent as he to impart instruction in so great a variety of subjects. His case is paralleled by that of the late Professor Cabell, of the University of Virginia, of whom it was said that he was qualified to fill any chair in the medical department of that University. It was remarked of Professor Miltenberger in the presence of many members of his profession, who had assembled to do him honor on April 30, 1896, upon the occasion of the presentation of his portrait to the Medical and Chirurgical Faculty of Maryland, that at various periods in his long and versatile career he had taught his pupils anatomy, pathology, clinical surgery, clinical medicine, therapeutics and obstetrics. With a slight paraphrase of Johnson's words in regard to one who in addition to being an ornament of literature was also a physician, *"nullum fere medendi genus non tetigit, nullum quod tetigit non ornavit."*

In 1890, having passed his threescore and eleventh year, Professor Miltenberger resigned the active duties of his chair and was appointed emeritus professor and honorary president of the Faculty of Physic, positions which he held until his death on December 11, 1905, in the eighty-seventh year of his age.

In the hall of the State Faculty his portrait was placed on the occasion above referred to as a tribute to his worth and as a token of the honor and esteem in which he was held by his professional brethren.

At a meeting of the Alumni Association of the School of Medicine in the University of Maryland, at which he presided many years ago, he suggested as a motto, which was adopted for that organization, the words: "Filius sim dignus ista digna parente," a sentiment and an aspiration which in his own character as a man and as a physician he worthily illustrated.

RESOLUTIONS.

The Medical and Chirurgical Faculty of Maryland having learned of the death of its fellow-member and Ex-President, George Warner Miltenberger, M.D., and desiring to place on record its high regard for him as a man, a physician and a teacher, have adopted the following:

Resolved, 1st, That in the death of Professor Miltenberger the Faculty has lost one of its most valued members and one of its most influential ex-presidents, the medical profession a man of scholarly attainments, one who had the welfare of his profession, as to its highest ideals, at heart; a trusted friend and a genial companion; the city of Baltimore a citizen, who through a long and laborious life has left an example of manly activity, zeal and honor which it would be well for all to emulate.

Resolved, 2d, That as a teacher in one of the foremost medical schools in this country for a period of nearly fifty years, he displayed marked ability and he devoted himself so unreservedly to medicine in all branches that he was able to fill all the chairs of the school with credit. He was an interesting as well as an instructive teacher and his genial manners and desire to promote in every way in his power the advancement of his students made him almost an idol with his classes. Throughout the country there are hundreds of medical men today who are doing valiant service

owing to the inspiration received from him during their student life.

Resolved, 3d, That he was a physician in the truest and loftiest meaning of that word. He carried with him into his daily life the highest ideals of medicine. He labored for the best interests of those who put themselves under his care and all the sick felt when brought into contact with him that a master mind was dealing with their condition. He was a physician who inspired the love and affection of his patients and the confidence he aroused when in the sick room gave him great power over his patients.

Resolved, 4th, That he has shown by his long lifework that by a strict adherence to duty and by following only those paths which lead to the highest and loftiest aspirations, a man may be eminently successful.

Resolved, 5th, That a copy of these resolutions be sent to the family of Professor Miltenberger, that they be spread upon our minutes for permanent record and that they be sent to the HOSPITAL BULLETIN of the University of Maryland for publication.

JOSEPH T. SMITH, M.D.,
FRANK D. SANGER, M.D.,
HUGH H. YOUNG, M.D.,
PHILIP BRISCOE, M.D.,
E. L. WHITNEY, M.D.,
December 20, 1905. Committee.

At a meeting of the Faculty of Physic of the University of Maryland held on December 12, 1905, on the occasion of the death of Dr. George W. Miltenberger, honorary president of the Faculty and emeritus professor in the University, the following minute was adopted:

"The Faculty of Physic of the University of Maryland hereby place upon their records their sense of the loss which they as a Faculty, the medical profession and the community have sustained in the death of Professor George W. Miltenberger.

"Although by reason of the great age which he had attained, Professor Miltenberger had retired for several years from the discharge of his active duties as a teacher and as a practitioner of medicine, yet the recollection of the admirable qualities which he possessed in both of these capacities will never be effaced from the memories of those whose privilege it was to profit by his instructions and by his professional skill."

"Out of the fulness of his acquirements he imparted knowledge and enthusiasm to his pupils and such benefit to those who came under his ministrations as inspired them with feelings of gratitude and love."

"His colleagues and friends feel that his highest and truest praise is the simple statement that his long life was spent in doing good."

It was directed that this minute be entered upon the records of the Faculty and that a copy of it be sent to Professor Miltenberger's family.

CORRESPONDENCE.

HOMEWARD BOUND.

To the Hospital Bulletin:

On the return trip from Alaska the ship's company was considerably changed, as many of the passengers had stopped at the various towns or passed into the interior; but there were many accessions of individuals and families, who were leaving these parts, either temporarily or permanently.

Of those who seek fortunes in the North, a few succeed, and many fail. On our ship two Scotchmen were returning, carefully guarding a bag of gold, said to contain $150,000 in dust and nuggets, whilst a number of others were returning in poverty. If you have enough money to go to Alaska, you had better stay at home; and if you haven't enough to see you through, don't think of going. One old man, with a family, mortgaged his property in Ohio and went to seek his fortune in the Yukon. In six months he had lost everything, and his wife and daughters were obliged to take in washing and do menial work for the miners to keep the family from starving. Strange to say, the wife was prospering in her business, and hoped to be able to pay off the lien on the farm in Ohio, and to return in two or three years.

The homeward voyage was not quite as enjoyable as the outward trip, as the weather was not so bright and warm, and mountain fires, which were beautiful at night, caused so much smoke as to obscure the view during the day. During a considerable portion of our return trip the revenue cutter "Manning," with a high Treasury official and his family on board, kept us company and used our ship as a pilot through dangerous straits. Schools of whales were passed, sometimes at close range, and at times a combat between a thrasher-shark and a whale would be witnessed, and it was said by the ship's officers that the whale

was usually killed by the shark. Aquatic birds in great numbers were seen, wild ducks being especially abundant. Here and there deserted Indian settlements would be passed, the natives having migrated, owing to some persecution. Old Metlakatla, in the upper part of British Columbia, was once a flourishing native town of 1,000 people, under the direction of William Duncan, a Scotch missionary; the Indians being taught trades as well as religion, and all white people being excluded. Owing to civil and ecclesiastical injustice, the natives abandoned their town and moved, with their pastor, to Annette Island, where they have built New Metlakatla, and are again prosperous and happy. For twenty-seven years Mr. Duncan has devoted his life to this work, and, though now an old man, is still earnest in his efforts for the temporal as well as spiritual upbuilding of the natives.

We reached Vancouver on July 29, where a number of our party left the ship, and returned Eastward by the Canadian Pacific road, whilst the rest continued the trip to Seattle, reaching there on the next day, after a most delightful and instructive voyage of eleven days.

July 31 found me at Portland again, where I was obliged to stop in order to have my tickets verified, and where I received letters and papers from home, to my great delight, after having been two weeks beyond reach. After spending the day at the fair, I took the evening train for San Francisco, distant two nights and a day from Portland—I imagine about 800 miles. On awakening on August 1 our train was crossing southern Oregon, and soon began to ascend the steep mountains separating this State from California. In crossing the Sisikyon Mountains, three engines were attached to the train, and many beautiful vistas were seen as the track twisted in and out up the mountain-side. Descending into California, a great change of temperature was experienced, and the heat was very oppressive. We now traversed valleys resembling those of Pennsylvania or Maryland, with waving fields of grain and grass, but with an absence of trees, to a great extent. At the railroad stations would be ornamental pavilions with exhibits of State industries of various kinds, and the train usually stopped long enough to permit passengers to at least obtain some idea of the productions of the country. For many miles, Mt. Shasta, with its snow-clad summit, was a beacon towards which we journeyed, and later we reached the beautiful Shasta Springs, a popular summer resort for the people of the cities. Another night on the sleeper and we passed through Chico and Sacramento, without being able to see anything of these cities, and on arising in the morning were approaching the coast. Oakland was reached about 8.30, where the passengers were transferred to a ferryboat and crossed the bay to San Francisco. In crossing, an amusing incident occurred: The day was rather raw and chilly, but a man named Brown, who had been somewhat conspicuous on the train, on account of a blatant voice, which was exercised very freely, drew great draughts of air into his lungs and swelling himself out, exclaimed, "Glorious air; so much ozone!" As far as I could judge the air was no better than any other raw sea atmosphere, but Brown was a good deal of a jackass. On the trip on the train I overheard a gentleman and lady make some remark about Baltimore, so I turned toward them, when they showed me a picture in a journal representing Baltimore street on January 1, and Los Angeles on a similar date. Our city was buried in snow, whilst Los Angeles was beautiful with flowers. I remarked, "I live in Baltimore," and the lady said, "that is my home, too, or was before I was married." She was the wife of a prominent specialist in Philadelphia and the sister of one of our graduates, practicing in this city.

At 9 o'clock one of my long-cherished desires was attained—I was in San Francisco. This city is said to have a population of 400,000, and is a handsome, bustling place, with many foreign and oriental characteristics. Its business houses and hotels are magnificent, being constructed of durable materials, whilst the residences are mostly built of redwood lumber, which is said to be more comfortable than brick or stone, as it is less pervious to moisture and at the same time is rather incombustible. The palaces of the millionaires on Nob's Hill and Vanness avenue are superb, and are usually surrounded by spacious grounds.

San Francisco is situated on a barren waste, with great irregularity of surface, but for the most part a succession of steep hills, from the bay on the east to the Pacific Ocean on the west. These bodies of water are connected by the Golden Gate, a beautiful strait about two miles in width and perhaps three miles in length. This channel, through which all oceanbound vessels must pass to reach the safe haven of the bay, is said to be equalled in beauty only by the Golden Horn at Constantinople. Around the city are seen high

hills and mountains bare of verdure, and showing a purple sheen in the distance. From the west one overlooks the mighty Pacific, of a deep blue color in the sunshine, with its rythmical swell, and as I saw it, placid and without the tumultuous waves so common on the Atlantic coast. San Francisco Bay is a large body of deep water, sixty miles in length and five or more in breadth, on the borders of which are Oakland and numerous other cities of considerable size. In this bay the navies of the world could find a safe refuge, and it would be very difficult for a fleet to enter with a hostile purpose.

My visit of only two days, though permitting a very superficial inspection only, afforded me facts for a much more voluminous communication than I am privileged to make at this time, and I must not linger much longer on this portion of my journey. There is a large Chinese population of at least 20,000 persons, living for the most part in a well-defined section called Chinatown, where they observe their native customs and dress. One cannot safely pass through this section without a guide, especially at night; but in a company and with an authorized guide it is quite safe to do so, though the Celestials evidently do not enjoy such visits. I visited Chinatown, and to all intents might have been in China itself. Their stores, restaurants, theatres, joss houses and homes were opened at the sesame of our guide, especially when a few American coins were added. The Chinese men wear pigtails, blouses and long tight trousers; whilst the women, some of whom are very comely, put their hair up in a coiffure, and wear blouses, with baggy pantaloons. At an opium joint, the proprietor, an old man, said he had smoked this drug since he was a young man, usually taking seventy-five pipefuls daily. I saw a number of men, in various stages of stupefaction, lying in bunks.

Leaving San Francisco at 6 P.M. on August 3, the State was crossed in the night, and we were crossing the Cascade range of mountains when I awoke the next morning—the summit being reached at an altitude of 7,000 feet. The descent was rapid, and the State line between California and Nevada was passed near Reno, which is quite a nice little city—an oasis in the desert. All day the train travelled across a barren waste, except where irrigation was practiced, when the land brings forth bountifully; often there was no sign of life, the ground being covered with an alkaline deposit. Water mirages were frequent, and one imagines a large body of water to be near, only to find it an illusion. At one of the most desolate parts of the desert, a large aquatic bird, probably a pelican, was seen standing with outstretched wings in the blazing sunshine. He, also, was probably deceived by the mirage and thought water was near. Frequent whirlwinds, of limited extent, could be seen from the cars as we passed along. Early on the morning of August 5 there was the rumble of the wheels as the train began to cross the Great Salt Lake on trestles. This bridge is about thirty miles in length and extends from east to west directly across the lake. On the west of the lake is the desert reaching from the mountains of California, across Nevada and part of Utah; but on the east is the beautiful and fertile valley, formerly a part of the bed of the lake, and bounded by the Wasatch Mountains. In this valley is situated the prosperous city of Ogden and the interesting and unique Salt Lake City. This land was discovered by the Mormons under Brigham Young, in 1847, and was at once occupied as a haven of refuge from persecution, where they hoped to be able to live in peace and to worship God according to the dictates of their own conscience. Salt Lake City was founded on July 24, 1847, and some of the early adobe houses are still in existence. At the present time it has a population of 75,000 inhabitants, and is a beautiful city, with wide streets and handsome residences, stores and public buildings. Its chief points of interests, however, are connected with the Mormon Church, of which this is the center. Brigham Young was a great organizer and executive and built his city and State on firm foundations. Taking an observation car, we can get a fair idea of the external appearance of the city in a few hours at a cost of fifty cents. The Temple is the most sacred edifice in the city, into which only the elect can enter. Its cornerstone was laid by Brigham Young in 1852, and it was completed in 1893. It is somewhat a gothic-looking structure, of white granite, quarried in the Wasatch Mountains, twenty miles distant, and transported in oxcarts to its destination. It is situated in a large enclosure, surrounded by a high wall, within which is also located the somewhat mushroom-shaped Tabernacle. This is an immense building, oblong in shape, 150 feet wide, 250 feet long and 80 feet in height. The roof springs from stone columns on each side and is unsupported elsewhere. It will seat 8,000 people, and is possessed of the most wonderful acoustic properties, as the drop-

ping of a pin, a whisper, or the rustling of a newspaper, as the pages are turned, can be distinctly heard at the end of the auditorium, 200 feet distant. Among other notable buildings are the Bee-Hive House, the Lion House, the Amelia House, which were all built by Brigham Young as residences for some of his favorite wives. The city is sixteen miles from the lake, to which trains run every hour. Great Salt Lake is 100 miles long and 60 wide in parts, but its area is constantly diminishing by evaporation. Its water contains 22 per cent. of salt, and an income of $1,000,000 annually is derived from the manufacture of salt. Saltair Beach Pavilion is perhaps the largest single bathing pavilion in the world, as it contains more than 800 separate rooms. The water is so buoyant that it is impossible to sink, and, indeed, it is nearly impossible to swim on the stomach, as the feet are lifted out of the water. One can easily float on the back, however. Bathing here has the disadvantage that the salt water is very irritating to the eyes and the nasal mucuous membrane, and that one is so covered with salt after his bath, that he must immediately wash in fresh water to make himself recognizable. I spent a most enjoyable day at Salt Lake, and resumed my journey to the East at night.

On August 6 we journeyed through Southern Wyoming, the train stopping at Rawlings a sufficient time to permit us to get a first-class breakfast of great variety, for which we paid 75 cents. The country is desolate looking, but as we traveled eastward it became more pastoral, with grass sufficient for horses and cattle, but no trees. Passing into Eastern Colorado, the landscape was that of a beautiful agricultural country, highly cultivated and productive. Denver was reached in the evening, and a four-hour stop gave me an opportunity to see something of this large and handsome city. The next day our route lay through Southern Nebraska, where we had an opportunity to observe the large farms, which were in a high state of cultivation. One of the most conspicuous features of the country, from the Golden Gate to the Missouri river, is the absence of trees, and it was indeed a great pleasure to again see the wide spreading oak and other familiar forest trees, as we entered the homestretch of our journey. The State of Missouri was traversed in the night, and on the morning of August 8 I reached St. Louis. Whilst standing in the great Union Station I heard my name called, and recognized Drs. Irvin and Matthias, graduates of our school, formerly living at Westminster, Md., but now practicing their profession successfully at Kansas City, Mo.

Across Illinois, Indiana and Ohio, flat and uninteresting in scenery, but thickly populated and prosperous; across the mountains of West Virginia, and the beautiful hills and lovely valleys of Maryland were reached, and with a deep sense of gratitude that my long journey had been made in safety, I reached my home.

In reply to any query as to my impressions of the West, I may be allowed to say that much of the country is wild and grand in its scenery; much of it desolate and barren in appearance; in some parts, like the State of Washington, the land is exceedingly fruitful and the conditions of life very agreeable, but for a pleasant land, one flowing with milk and honey, with beautiful forest-clad hills and homelike and fertile valleys, with mountains in the west and broad rivers and bays in the east, the State of Maryland is equal, if not superior, to any part of the United States that I have visited. RANDOLPH WINSLOW.

The following complimentary letter, accompanied the notification of election of Professor Randolph Winslow to a fellowship in the Southern Surgical and Gynecological Association:

DEAR DOCTOR:—I take pleasure of informing you officially of your election to fellowship in the Southern Surgical and Gynecological Association at the meeting in Louisville, December 12-13-14. The Association feels that in honoring you it has honored itself, and I assure you that it is an actual pleasure to me to see your name enrolled with so many of your friends in the Association which we believe is doing the highest class of scientific work in this country. I feel, with the enrollment of the best men, the standard which the Association has set for itself will be maintained.

Curiously enough, the recent election of fellows, including yourself, exactly filled the constitutional limitation of membership, and, hereafter, only those will be elected to the vacancies which are caused by death or resignation. The next meeting will occur in Baltimore next December, and Dr. Howard Kelly will be chairman of the committee of arrangements. I dare say that it will be one of the most brilliant meetings in the history of the Association, and I trust nothing will prevent your being present. With greetings of the season, I remain, Very truly yours,

W. D. HAGGARD, JR., M.D.,
Secretary.

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EDITORIAL

WHAT THE UNIVERSITY OF MARYLAND HAS DONE FOR THE PEOPLE OF MARYLAND.—Since the Medical Department of the University of Maryland was organized in 1807 this school has been in continuous operation and during the wars in which this country has been engaged has not closed her doors for any part of a session.

Such a history as this is worthy of note, for during the Civil War, Baltimore institutions, in common with the State, suffered by reason of their proximity to Southern territory. Whilst resignations from the Faculty were not infrequent during that period, the work of the University was not interrupted. During the ninety-eight years of work the Medical Department has conferred the degree of M. D. upon 5,329 graduates —a record surpassed by but few medical schools in this country. The graduates of the University have filled the positions of Surgeon-General of the Army and of the Navy, have been distinguished members of all branches of the United States medical service, have filled chairs in many of the leading medical schools of the United States, have been members of Congress and of the United States Senate, and in all walks of the profession have had useful and distinguished representatives. The graduates of the University have carried the fame of Maryland to all sections of the world and the people of Maryland have just cause to feel proud of an institution which has done so much for the State.

Viewing the results of the work of the University from an educational standpoint, the people of Maryland owe a debt to this old institution which cannot be estimated in dollars and cents. The moral weight of such an institution to any community is a factor of greatest consideration in estimating public service, but apart from these influences the commercial value of an institution of learning to a community should be reckoned as a most valuable asset. Viewing the work of the University during the past ninety-eight years from this latter point of view, the service rendered the people of Maryland by the graduates of the University in the capacity of educated citizens, as officers of public health and in service rendered to the sick cannot be overestimated. There is no equivalent for the labor of an educated class in a community. In this account of the work of the University of Maryland reference has only been made to the services of the Medical Department. If there be added to this work the services rendered the State by the Law, Dental and Pharmaceutical Departments, the combined forces of the University of Maryland must be taken into consideration.

Do the people of Maryland fully realize the large service the University of Maryland is rendering in all of her departments? Judging the past by results, we must answer this question in the negative. The State by her appropriations to institutions of education has done but little for the University of Maryland. When she has appropriated money to the University she has always imposed conditions which were as serviceable to the people as to the institution. It can be shown that every dollar given the University has been expended in improving State property or in maintaining the State poor. The faculties of the University have contributed more to improve the property of the University, which belongs to the State, than has the State, and the only benefit which has come to the teaching bodies has been through the better facilities which the State has helped to create. In few States has the State University received so little from the State as has the University of Maryland.

Shall this condition of affairs continue indefinitely?

THE WOMAN'S AUXILIARY BOARD OF THE UNIVERSITY HOSPITAL.—In the last issue of the BULLETIN the report of the Woman's Auxiliary Board, for the year ending November 1, 1905, was published in full. We cannot permit this report to pass by unnoticed. Whilst the report speaks for itself and tells how much the Board did for the Hospital it does not tell one-half the good things the members of the Board have done for the good of the Hospital and for the comfort and happi-

ness of the patients. The material results are striking enough to arouse the appreciation of every one connected with the work of the Hospital, but these are but trifles in comparison with that kindness, charity and thoughtful consideration which was shown from day to day by visiting members of the Board to the sick and afflicted in the Hospital wards. Words of hope and kindness, delicacies for the appetite, clothing for those in need, flowers to brighten, and many other deeds of charity, were not spoken of in this report, and yet they were most freely given and most gratefully received. No one can estimate the true value of the service the Woman's Auxiliary Board has rendered the Hospital, for its influence is so quiet, so unostentatious that it is not seen, but only felt. Those who have charge of the treatment and nursing of the sick fully realize the value of the service which members of the Board render those under their care by their administration of little attentions and words of cheer and hope. These little charities are twice blessed, they bless those who give as well as those who receive. This is God's good work the Woman's Auxiliary Board is doing for the Hospital and its inmates.

The Growth of Medical Education in Maryland.—In the issue of the *Maryland Medical Journal* for December, 1877. we find the following statement: "We understand in the neighborhood of three hundred medical students have matriculated at the two medical schools in this city, and that this is the largest class which has assembled for five years."

This condition of medical education in Baltimore twenty-eight years ago shows the remarkable growth in medical instruction since that time. As far as we are able to collect statistics there are at present in attendance at the medical schools of this city about 1,700 students. At the University of Maryland over 330 students have matriculated in the medical department, or more than all the schools of the city had in 1877. When it is remembered that the course of instruction in 1877 was two years, whilst the present course of instruction is four years, the size of the student body represents a most striking advance in educational work. Baltimore has grown so rapidly as a center of medical education that the influence of this large student body is a striking factor in her industrial progress.

Such a large body of students contributes a great deal to the prosperity of this city, and may be considered a most valuable asset from a monetary standpoint, to say nothing of the larger influence which it must exercise in every community.

We ask the gentlemen who compose the Board of State Aid and Charities, who have recently ruled that the Baltimore medical schools are private corporations, and, therefore, are not entitled to pecuniary aid from the State, whether they have given fair consideration to the claims which our medical schools have made upon the treasury of the State? Have not a few of the results in medical education been reached through the support which the State has given, and will the State now withdraw its aid and retard the progress which these medical schools are making in the development of a great medical center in Baltimore? These are practical questions which involve the interests of many people in Maryland. The amount of money given by the State is a small return for the service the medical schools of Baltimore are rendering our people.

Nothing but a narrow and contracted policy could father such a spirit of stinginess and illiberality. Fortunately, wise and generous men, as a rule, make our laws and build up our public institutions, and it is to this class of men that the medical schools of this city must appeal for encouragement in the important work they are doing in building up a large student body in this city.

Professor George Warner Miltenberger, M. D.—Professor Miltenberger, who died at his residence in this city on December 11, in the eighty-seventh year of his age, was, perhaps, more widely known to the alumni by reason of his long connection with the University than any of the distinguished men who have filled chairs in the medical faculty. Graduating from the University in the class of 1840, he was that same year appointed demonstrator of anatomy, and filled the position until 1847, when he was made lecturer on pathology. In 1852 he was elected professor of materia medica and therapeutics, and in 1858 was transferred to the chair of obstetrics, which he filled until 1891, a period of thirty-three years. Owing to his advanced age, he resigned from the faculty in 1891 and was made emeritus-professor. Thus for the long period of sixty-five years he was connected with the faculty of the University and most ably contributed to the success and re-

nown of his alma mater. During all this time he was most loyal and devoted to the interests of the University and gave his best energies and talents in her behalf.

Whilst Professor Miltenberger was best known to the alumni and medical profession as an authority and teacher in obstetrics, he was more widely known to the public as a general practitioner, and, perhaps, no physician in Baltimore has ever had so large a hold upon the public as a general practitioner as he had. He represented the very highest type of the family physician, giving his services to rich and poor, without favor or distinction, and with no consideration for his personal comfort. Active, energetic and enthusiastic he labored in his profession as few men have labored in any cause. His courtesy, genial and affectionate nature, honesty and skill won the esteem and regard of all who knew him. As a teacher he was clear, forceful and at times eloquent, while with his dignity, urbanity and wide knowledge of his subject commanded the attention and respect of all who attended his lectures.

As much as we must admire Professor Miltenberger as a teacher and practitioner, he is entitled to the highest esteem for his manly, upright and sterling personal characteristics. His devotion to wife, kindred and patients, his loyalty to his friends and to the old University, his love for truth and his broad charity were fully exemplified in every detail of his life.

Since retirement from the active work of his profession, some fourteen years ago, he has lived a dignified and serene old age at his residence, devoting his time to the education and training of his young relatives, to the claims of his dearest kindred and to profitable reading. He was always cordial to his old friends and at all times interested in the progress of his profession.

Passing away at a ripe old age he had lived to see large results and marvellous developments in American history and in scientific knowledge. His part in the work of his generation was a most creditable one, and he has well earned the rest into which he has entered.

The Carroll County Medical Society of Maryland has elected the following of our alumni officers: President, Dr. J. Howell Billingslea, 1864, Westminster; vice-president, Dr. George H. Brown, 1864, New Windsor; secretary-treasurer, Dr. Charles R. Foutz, 1897, Westminster; censor, Dr. J. Clement Clark, 1880, Sykesville.

ABSTRACTS AND EXTRACTS.

At the November 13, 1905, meeting of the Baltimore Medical and Surgical Association addresses were delivered by Professors Joseph E. Gichner, and Charles O'Donovan, 1881.

In his subject, "Malignant Scarlet Fever" (namely, cases of great virulence developing and dying within thirty-six hours), Dr. O'Donovan briefly outlined the diagnosis, prognosis, differentiation, theory of etiology, and treatment of this exanthem. According to European authorities, scarlatina is due to a streptococcus infection gone astray, but another group of investigators and scientists attribute its etiology to a distinct scarlatinal organism too minute to be perceived through the microscope. Death is due to a specific toxemia, sufficiently strong to overcome the individual's vitality. Owing to its uncertain termination he approaches this malady in his practice with a great deal of respect and trepidation, because you have no guide to the degree of malignancy by the symptoms at the inception of the exanthem, very often apparently mild cases developing within a short period into ones of great virulency. Epidemics, it is well known, take on different degrees of severity, severe cases developing out of moderate epidemics as well as from grave cases, and *vice versa,* mild cases are known to arise from the severest. It is, therefore, impossible to diagnosticate or prognosticate at the inception of the disease as to the degree of severity, as there are no indications that manifest themselves in order to warn against death within thirty-six or forty-eight hours.

Treatment—As conditions arise they have to be met symptomatically, when the temperature reaches 105°; employ the ice pack, if it should reach 106°, in spite of the fact that children do not stand ice baths very well; immerse the patient in a tub. Apply an ice cap to the head, unload the stomach, and keep the bowels freely open by the use of rectal enemata. For convulsions administer chloral, bromides, and in severe instances a few whiffs of chloroform may break up the attack. In true malignant scarlatina, however, these efforts are usually futile.

Dr. Gichner presented his subject, "Myocarditis More Important Than Valvular Diseases of the Heart," from the viewpoint of a clinician, only touching briefly on the pathological aspect. Owing to the frequency and the lack of adequate

signs at our disposal to arrive at an accurate diagnosis of myocardial degeneration, Dr. Gichner considers interstitial involvent of this organ of more importance to the practitioner than valvular defects, which manifest themselves symptomatically, thus definitely localizing the seat of trouble. Moreover, most valvular lesions, as a general rule, are associated with a greater or lesser degree of myocardic changes. In any long continued, lingering illness, the subsequent regeneration of the cardiac tissue is liable to be incomplete. In such diseases as sepsis, typhoid fever and many others, as well as in inveterate users of tobacco and alcohol, although the microscope is unable to detect any recognizable lesion, still there is a degenerative process present. As the heart muscle is dependent upon proper nourishment for its proper activity, in malnutrition degenerative processes supervene. In pure myocarditis there is no thickening of or vegetations on the valves. In emphysema and nephritis the heart has to overcome a great obstruction, which strain sets up a parenchymatous or an interstitial degenerative process. In many instances after diphtheria, the heart is tardy in reaching its normal condition; indeed, it often never fully regains its erstwhile healthy state, remaining somewhat abnormal throughout life. In long continued fevers we wonder how well the heart has borne the extra tax, yet during convalescence upon the slightest demand it will break down, in some instances the dilated heart being unable to hypertrophy and force the blood through the vessels the patient expires. An engorged heart manifests itself differently in different persons. Usually there is dyspnoea upon exercise, either physical or mental; for worriment is capable of causing dilatation. Cardiac distress is by no means uncommon in a non-compensating heart. An intermittent or arhythmic pulse, palpitation and angina pectoris, which are often attributed to neurasthenia, are often a resultant of an organic affection of the heart's musculature. One of the first symptoms of a dilated heart is epistaxis, and edema of the feet is nearly as common a sign. A myocarditic heart is often fairly regular in rhythm; in fact, many times nothing abnormal can be found, but upon careful examination the pulse which is rhythmical and regular when the patient is quiet, upon the slightest exercise increases in rapidity and becomes irritable as well as arhythmical. In these cases examine the patient systematically and in many instances you will be rewarded by the discovery of the apex beat well to the left of the nipple line. Indeed, amongst the premonitory signs of a failing heart is the displacement of the apex impulse. Moreover, the impulse is of a heaving nature, accompanied in some instances with a bruit at the mitral valve, simulating a mitral insufficiency which disappears with four to six weeks' rest, to return without a moment's notice after some extraordinary strain or excitement. Do not make a diagnosis of organic cardiac trouble, because you have found no valvular lesion, but correlate all the symptoms, both objective and subjective, and you may perhaps be enabled to arrive at reasonably correct conclusions, although there are so few indications of myocardial disease. The principal signs of myocarditis may be summarized as follows: (1) A markedly dilated heart with its chain of symptoms is frequently encountered; (2) When the patient is quiet there is no arhythmia of pulse, but upon the slightest exertion, a marked increase in the pulse rate associated with irregularity, is noted; (3) Upon repeated examinations we find a beat much lighter in its impulse than its fellows; (4) Cyanosis and asthmatic symptoms are common complications of this malady; (5) Upon auscultation a slight moisture will be heard in the lungs; (6) Precordial distress is by no means uncommon.

Treatment--Digitalis, unless employed judiciously, will do more harm than good. When administered the patient should be kept in bed and quiet. Diminish the intravascular pressure when too great with nitroglycerine; supply tone to the circulartory system when lost with strychnia; a medium tone of the vessels is what is desired. If intrathrocacic pressure is disturbed by an overdistended stomach, empty this viscus with the proper remedies, *i. e.*, calomel in broken doses, followed by a brisk purge. In anemia, such as encountered in women, who have not a healthful hypertrophy, with a heart prone to dilate, combine the Schott baths with exercise and hygienic management.

The employment of iron, quinine and strychnine as tonics may exert a beneficial influence. Oxygen and fresh air, with freedom from care and work, with precaution against overeating or indulgence to excess of any nature, work marvels in conquering this malady.

NOTES AND ITEMS

Dr. J. Pinkney Turner, class of 1896, is the coroner of Greensboro, N. C.

Dr. Hyatt, of Goldsboro, N. C., has been taking a post-graduate course at the University.

The engagement of Dr. Lewis Morris, class of 1890, United States Navy, has been announced.

Dr. Nathan Winslow, class of 1901, has been appointed a lecturer on surgery in the University of Maryland.

Another visitor to the Hospital during the past month was Dr. S. Baskin Sherard, class of 1905, of South Carolina.

The Duncan family held a reunion at the home of Dr. Edward M. Duncan, 1884, Govanstown, Maryland, November 29, 1905.

Fitz Randolph Winslow, class of 1906, who was recently operated upon in the University Hospital, is reported to be convalescing.

Dr. A. D. McConachie, class of 1890, has been elected a director of the Northeastern Dispensary, to serve for three years.

Dr. Richard H. Speight, Jr., has resigned his position of assistant physician of the State Hospital for the Insane, Morgantown, N. C.

Miss Margaret Cowling, class of 1905, has been appointed superintendent of the hospital recently opened at Newberne, N. C.

Among the visiting physicians recently seen at the University Hospital was Dr. J. R. Martin, class of 1904, of Pennsylvania.

Miss Sallie T. Daugherty, a graduate nurse of the class of 1904, has recently been appointed superintendent of the Cambridge Hospital, located at Cambridge, Md.

Dr. E. J. Hansen, class of 1904, located in New York city, has made a recent visit to his old friends in Baltimore.

Dr. Joseph T. Coulbourn, class of 1886, residing at 1701 Avenue J, Birmingham, Ala., visited the Hospital while on his way home from a northern tour.

Miss Sallie T. Daugherty, class of 1904, who recently had her appendix removed by Dr. J. McFaddin Dick at the Salisbury Hospital, is reported to be making favorable progress.

Dr. William Gross Harrison, 1892, of Talladega, Ala., a former assistant resident surgeon in the University Hospital, has returned to his home after a year's residence in Europe.

Dr. Robert T. Wilson, class of 1881, surgeon to the Woman's Hospital of Maryland, has been elected president of the Hospital Relief Association of Maryland.

Dr. H. W. Wickes, passed assistant surgeon, United States Public Health and Marine Hospital Service, has been granted leave of absence for one month from December 20, 1905.

Dr. William Gassaway, class of 1904, of Sharpstown, Wicomico county, Md., visited the Hospital on December 7, 1905. He is much pleased with his location.

Dr. John T. O'Mara, class of 1903, until recently a resident physician at St. Agnes' Sanitarium, has located at 1012 Edmondson avenue, Baltimore.

Dr. M. B. Crockett, class of 1895, University College of Medicine, Richmond, Va., of Knob, Va., has been taking a post-graduate course at the University of Maryland.

The resident physicians of the University Hospital gave their annual Christmas dance in honor of the nurses of that institution, in the reception-room of the Hospital, December 26, 1905.

Dr. V. W. Brabham, class of 1905, resident physician in the Maternity Hospital, has resigned, and will take up the practice of medicine in South Carolina.

At a meeting of the board of trustees of the endowment fund, Hon. Henry M. Stockbridge was elected president, and Mr. J. Harry Tregoe, secretary and treasurer of the board.

Dr. Howard V. Dutrow, of the class of 1904, of Frederick, Md., has been appointed a physician in the United States Marine Hospital at Panama. He sailed from New York January 1, 1906.

Dr. A. Leo Franklin, class of 1902, a former assistant resident gynecologist of the University Hospital, but now practicing in Cumberland, Md., spent his Christmas vacation in Baltimore.

Calvin D. Snyder, class of 1898, contract surgeon United States Army, now stationed at Fort William McKinley, Rizal, Philippine Islands, has been ordered to proceed to San Mateo, Rizal, for duty.

Professor Randolph Winslow has been elected president of the North Carolina Society. This society is composed of North Carolinians who have emigrated from their native State, and are now residents of Maryland.

In the *Journal* of the Alumni Association of the College of Physicians and Surgeons is an eulogy of Dr. Thomas Opie by his colleagues, Drs. Thomas Latimer, class of 1861, and Charles F. Bevan, class of 1871.

Dr. Benjamin Dorsey, class of 1901, a former assistant resident obstetrician in the University Hospital, but now an assistant surgeon in the United States Navy, is visiting his father, Mr. Joshua W. Dorsey, of Ellicott City, Md.

At the annual reorganization of the board of governors of the Baltimore Athletic Club, Dr. B. Merrill Hopkinson, class of 1885, was re-elected president to serve for the fourteenth consecutive year.

Dr. S. B. Buck, class of 1904, of Kansas City, Mo., who has returned to Wytheville, Va., his former home, to recuperate from an attack of malarial fever, has been spending a few days in Baltimore.

Among those present at a reunion of the Benson families held Christmas Day at the residence of Rev. Joshua L. Benson, at Berean, Md., were Dr. and Mrs. Benjamin R. Benson, class of 1873, and Dr. and Mrs. J. Edward Benson, class of 1884.

During the Christmas holidays Dr. Arthur M. Shipley, class of 1902, superintendent of the University Hospital, spent a week with his former room and classmate, Dr. H. L. Rudolph, a former assistant resident surgeon in the University Hospital.

Dr. Gideon McD. Van Poole, class of 1899, assistant surgeon United States Army, having arrived on the transport Thomas at Manila, has been ordered by the commanding general, department of Luzon, to report at Cuartal Meisic, Luzon, for duty.

Dr. Joseph A. White, class of 1869, of Richmond, Va., was painfully injured in an accident December 31, 1905. He was driving across the street when an electric car struck his buggy, wrecking the vehicle. In spite of two broken ribs, Dr. White has so improved as to be able to resume his professional duties.

Dr. E. B. Quillen, class of 1904, formerly resident pathologist of the University Hospital, but now superintendent of the Atlantic Coast Line's Hospital located at Rocky Mount, N. C., was in Baltimore recently on business connected with his new appointment, and stopped at the University to see his old friends.

At the annual convention of the Seaboard Medical Association recently held in Newport News, Va., the following alumni of our school were elected to the office prefixed to their name: Vice-president, Dr. Benjamin R. Gary, class of 1891, of Newport News, Va.; secretary, Dr. John R. Bagby, class of 1891, also of Newport News, Va.

Health Commissioner Bosley (Baltimore) has announced the following appointments: Drs. J. Howard Iglehart, class of 1903; A. Duvall Atkinson, class of 1894, and W. H. Clendinen Teal, class of 1897, as medical inspectors of public schools. The appointments date from December 1, 1905.

Health Commissioner Bosley, Baltimore, Md., has announced the appointment of Dr. Howard D. Lewis, class of 1900, as health warden and vaccine physician for the twenty-second ward,

vice Dr. Albert T. Chambers, class of 1898, resigned. Dr. Lewis was formerly a health warden in the department, but resigned about a year ago on account of ill health. His health is now completely restored.

Dr. John Edgar Rooks, class of 1905, who has been practicing his profession at Cahagan, La., has moved from there to 340 Randolph Building. Memphis, Tenn. In a recent letter from Dr. Rooks to the BULLETIN, he expresses himself as much pleased with the city of Memphis, and the outlook there for professional work. The BULLETIN extends him its best wishes in his new field of work.

Among the successful candidates at the fall examinations before the Maryland State Board of Medical Examiners were the following of our alumni: Vance W. Brabham, class of 1905; James Knox Cole, class of 1902; William Henry Fisher, class of 1905; George B. Harrison, class of 1905; Harry E. Jenkins, class of 1905; Newdigate M. Owensby, class of 1904; William Ellicott Elisha Tyson, class of 1905; Reuben A. Wall, class of 1904.

The following officers were elected to serve for the ensuing year by the University of Maryland Alumnæ Association of Nurses at their annual meeting, December 4, 1905: President, Miss Rolph; first vice-president, Miss Grey; second vice-president, Miss Ravenel; treasurer, Mrs Nathan Winslow; secretary, Miss M. S. Brown; executive committee, Miss Bradbury, Miss Mamie Cooke.

At the annual meeting, in January, the State Association of Nurses will be the guest of our Alumnæ Association.

The following committee, Mr. A. B. Clarke, class of 1906 (medical); Mr. L. J. Kosminsky, class of 1906 (medical); Mr. J. H. Skene, 1905 (law), and Mr. S. M. Goldman, 1906 (pharmacy), in charge of the benefit performance of "The Galloper," the farcical comedy, written by Mr. Richard Harding Davis, and with Mr. Raymond Hitchcock in the leading role, at Ford's Opera House, Baltimore, December 18, 1905, arranged for the purpose of defraying the deficit of publishing last year's annual, *Terra Mariae*, report that they were highly gratified at the large and representative audience present, thus making it possible for the committee to realize between three and four hundred dollars.

The following officers were elected by the Adjunct Faculty of the University of Maryland at their meeting of December 7, 1905: President, Dr. James M. Craighill, 1882; vice-president, Dr. Francis M. Chisolm, 1889; secretary-treasurer, Dr. Louis M. Allen, 1896.

The following committees were relieved of further duty, their term of office having expired:

Invitation and Reception.—Drs. St. C. Spruill, L. M. Allen, W. D. Scott, and D. Reeder.

History.—Drs. A. D. Atkinson, G. Wilson, C. W. McElfresh, and A. M. Shipley.

Faculty.—Drs. John R. Winslow, J. M. Hundley, F. M. Chisolm, and A. M. Shipley.

MARRIAGES

Dr. Herbert Elmo Zepp, class of 1904, a former assistant resident physician in the University Hospital, now of St. Michael's, Md., was married December 6, 1905, to Miss Grace Linwood Northam, at the home of her father, Mr. Levi Jacob Northam, Kegotank, Accomac county, Va.

Dr. Howard V. Dutrow, class of 1904, who was recently appointed a surgeon at Panama, was married December 14, 1905, to Miss Emma Agnes Thomas, of Frederick, at the home of the bride.

Dr. William Russell Rogers, class of 1901, Bristol, Va., an ex-assistant resident surgeon in the University Hospital, and son of Mr. and Mrs. John R. Rogers, and Miss Nataline Haynes, daughter of Judge Hal H. Haynes, chancellor of the Second Tennessee Division, were married December 20, 1905, at the home of the bride, on Anderson street, Bristol, Va. The BULLETIN extends to the young couple its congratulations.

Dr. James Stewart Akehurst, class of 1900, was married November 29, 1905, at Stewartsville, N. J., to Miss Agnes Vance.

Miss Julia Rena Willson, third daughter of Dr. Thomas Bennett Willson, class of 1866, was married at the home of her father, Edesville, Kent county, Md., Tuesday, January 2, 1906, to Mr. Harry Skirven, of Fairlee, Md.

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"SOME REMARKS ON SURGERY OF THE UPPER ABDOMEN."

BY FRANK MARTIN, M. D.,

Clinical Professor of Surgery, University of Maryland.

Mr. President and Gentlemen of the Medical and Chirurgical Faculty:

Through the kindness of your committee I have been asked to speak on some of the recent advancements in surgery, but I fear time forbids my attempting to even touch very briefly upon the many newer discoveries that surgical endeavor has brought about in recent years. There are any number of worthy topics pertaining to improvements in all the special departments of surgery that one could possibly take up with advantage—much advantage—but in thinking the matter over I am convinced that none of the recent advancements in any branch of surgery can in any way compare with the brilliant achievements that have been accomplished in that field of surgery known as the upper abdomen, and I feel that a few words pertaining to this region would be more advantageous, and yet I hesitate because so many valuable contributions have been added to the literature upon this subject by the world's best surgeons that I fear my remarks will be rather trite and threadbare, and among these articles the best, I am proud to say, have been by American surgeons.

The upper abdomen is a large field, vastly fertile, complex, intricate and more productive of serious pathological lesions than the majority of us are wont to believe. It is today distinctly regarded as belonging to the domain of surgery. The surgical borderland lies now in the upper region of the abdomen, and it was only a few years back that this locality was considered almost purely medical. Now the internest and surgeon work hand in hand.

(Read before the Medical and Chirurgical Faculty at Deer Park, September 21, 1905.)

In my earlier days I might say it was practically never invaded by the surgeon, nor were we taught that pathological lesions here were to be dealt with surgically. The reason for this change in advance is plain—surgery has done more to open up these complex problems and to advance our knowledge of the various lesions in this region than any other branch of medicine, and, by resorting to operative interference early, has enabled us to bring into use curative means, when the time was still ripe, before the primary conditions had advanced and complications arisen, which have caused the findings to be very chaotic and the operations, in consequence thereof, often fatal.

These advancements primarily came about after surgery had profited much by the research work of the pathologist, and seeing so often how many times at the autopsy findings that the original lesion had been but slight and at one stage easily curable, and the pathology present largely due to the results of secondary complications and terminal infections, surgery, with its strong forces behind it, which were born with the firm establishment of the Listerian principles of surgical cleanliness and made perfect by a thorough development of sound surgical technique, opened the door, entered this field and began the crusade in this domain on lesions in their infancy, while the patient could be still benefited and no longer waited for the post-mortem to reveal end results with their long chain of lesions.

Someone has well said: "The post-mortem has been an institution for years, yet what did we know about appendicitis until surgery led the way, or about gall-stone disease, supposed to be an innocent post-mortem finding, until operation opened up the field?"

Dr. Kehr, in his valuable book on gall-stone disease, speaking of this point, says: "In fact, very frequently gall-bladder disease, with its perverse hypocricy, conceals under a beautiful mask its horrible features, and unless we surgeons now

and then, upon a time, had the courage, with skillful hands, to tear off its mask, we never would have obtained a conception of the knaveries and wiles of cholelithiasis."

The profession now freely admits that surgery took the initiative and brought about the great achievements and brilliant advances in this region, and it is just here that surgery has won for itself some of its greatest triumphs. In a rapidly growing field of this character there were of necessity many alternating or changing cycles of symptoms, which led to confusion in diagnosis and treatment, due largely to an attempt to study one organ independent of the associated organs, and disregarding the close relationship which existed here between the organs, their anatomy, function and pathology, which are so closely allied, I might say, as to be almost necessarily considered as part of the same system. This close association of surgical lesions is now well recognized, and we no longer attempt to study independently the pancreas, duodenum, bile passages and stomach, because a lesion affecting one so often refers its symptoms to one or the other of the organs. Surgery has to meet lesions arising from any one or all of these organs. The clinical study and subsequent early operations upon acute conditions arising in this region has made possible a knowledge as complete and exact concerning these conditions as we have of the pathology of general medicine; in some particulars it is even a better picture, for within the same hour we may study the clinical phenomena and pathological states causing them, and that in so many stages that the pictures of the disease in its many varieties may be plainly understood.

I do not wish to convey the idea that the clinician can discriminate and diagnose accurately each and all of the varied conditions that arise here, for this is still absolutely impossible, but in the majority of cases we can arrive at a diagnosis pretty accurately, and the more one works in this region the better fitted, of course, he becomes in arriving at a proper diagnosis. We can say pretty accurately, for instance, "that this is gall-stone disease," or "this is ulcer of the stomach," but it behooves us not to be disappointed if an error in diagnosis is made and the findings at operation are not just what we expected would be present. We must bear in mind that the upper abdomen, so called, has closely associated so many important structures, and just here I would quote from Dr. Wm. J. Mayo, who emphasizes this point better than I can, "that the palm of a hand may cover a serious lesion of any one of these organs and that, too, at the point of greatest liability; not only so, but any one of this group may start a pathological process which may extend to any one of the others, and if we clearly understand the possibilities of error, naturally we are better prepared to execute a change of front and operate upon one organ when another procedure was planned."

The two greatest achievements that surgery has accomplished in this region unquestionably have to do first, with the strides it has made in gall-bladder surgery; secondly, the brilliant results accomplished in stomach surgery. Then, too, with the less common and more grave conditions come those of perforations pertaining to the organs of this group, which are not as keenly recognized, I am sorry to say, as those occurring in the organs of the lower abdomen. Here a diagnosis of perforation can usually be made, but it is always difficult to say which organ is affected. This is not necessary. The most important consideration is that it has happened and an immediate operation must be performed. To delay, in the endeavor to make an exact diagnosis in a condition of plain gravity, is folly, and by so doing a life is often sacrificed.

The weak point today in the treatment of these perforations is our failure to recognize them early enough for a successful operation. The mortality in consequence is very high. If we could deal with them as speedily as we now operate upon gun-shot wounds of the abdomen we would make a better showing. In the near future I am confident we will see that these conditions will be dealt with more promptly, as they are today in the lower abdomen, and with it will come a decrease in the mortality.

The group of maladies included under the head of gall-stone disease head the list in this quadrant, and it has been said that the gall-bladder furnishes the initial lesion in more than one-half of the diseases of this group.

Cholelithisais, with acute cholecystitis and empyena of the gall-bladder, occur most frequently. The former is infinitely more common than we have heretofore had any conception of. Ochner has made the diagnosis of gall-stone disease much simpler by maintaining "that in nearly all cases of gastritis the symptoms in reality are due to gall stones," and the varied list of stomach

symptoms complained of are simply secondary to cholelithiasis as the primary cause. The gall-bladder is unquestionably overshadowed by the symptoms supposedly due to stomach lesions. This I have noticed well emphasized in most of my series of cases. The symptoms of acute cholecystitis, or empyema of the gall-bladder, as I have observed them, have been those of a confined abscess at the border of the right costal cartilages and associated invariably with pain and tenderness and should not be mistaken, as it so often is, with appendicitis.

A word as to jaundice having to do with this group of maladies. I beg to call attention to the error of the prevailing idea that in acute affections of the gall-bladder, such as come on from cholelithiasis and cholecystitis, &c., that jaundice must be present. This is not true. From my observation, it seems to me that the prevailing idea "that to gall-stone disease belongs jaundice has no longer any value," and even with cholecystitis and acute empyema of the gall-bladder we meet jaundice only when the inflammatory process in the gall-bladder has extended to the mucous membrane of the cystic and common ducts. Jaundice, according to Brewer, is absent in from 80% to 90% of all operative cases, and the clinician should never hesitate to make a diagnosis of diseases of the biliary passages because of the absence of jaundice.

As to the condition revealed by palpation of the gall-bladder region. Abdominal palpation in arriving at a true diagnosis in these conditions is exceptionally important, but an error often prevails here as it does with jaundice. The prevailing idea is that palpable gall-bladders go with gall-stone disease. This is not so, unless the gall-bladder has perforated and inflammation has extended around it, then we have a palpable mass, but not a palpable gall-bladder. Palpable gall-bladders come, as a rule, with painless jaundice, which has been continuous and progressive and slowly deepening in intensity and due in the vast majority of cases to maligant disease.

I would like, in passing, to call attention to Courvoissier's law, to which Cabot calls attention to the widespread neglect of, viz: "when the common duct is obstructed by other causes, such as malignant growth, dilatation of the gall-bladder is common." This to me is an important point, because many seem to think that by careful palpation they can feel gall stone in the gall-bladder. This I believe to be exceedingly rare, as I have just said, when we can palpate the gall-bladder it means that it is distended, and generally malignant disease is the cause of that distention. With stone obstruction we have a contracted gall-bladder which can practically never be made out. I have seen this law well borne out in most of my cases, and where one has to do with a deepening, painless jaundice, progressive, with emaciation, and a palpable gall-bladder, one will almost invariably find cancer as the cause.

Our knowledge here has made rapid and permanent advances, and we know that the starting point of all these affections of the biliary passages is due to gall-stones, which, it is said, are so frequent that they are found in about seven per cent. of all people and prove fatal in about ten per cent. of this number. It is also well known that gall-stones, apart from the infectious diseases here mentioned, unquestionably are the starting point of malignant disease of this organ.

There is no longer any diversity of opinion as to how to treat gall-stone disease. None of the profession now cherish the delusion that gall-stones can be dissolved. The leading opinion is today that they should be removed wherever they are known to exist, whether they offend or not. The three most common operative procedures are cholecystectomy, cholecystostomy and choledochotomy, cholecyst-enterostomy being resorted to only as a palliative means.

Following upon the rapid advancements in this field there has come a better technique, and with it a much lower mortality following each of these operations.

Mayo's statistics show in a series of 1,100 operations for gall-stone disease a mortality of less than one per cent. in cholecystostomies, where there was simple gall-stone disease in otherwise normal individuals, or 2.44 per cent. as the *actual mortality* in 820 cases. The same author's statistics do not speak so encouragingly for choledochotomies or common-duct operations; out of 137 operations in benign cases there were 16 deaths, or a mortality of over 11 per cent. This sufficiently emphasizes the seriousness of common-duct operations; operations here for malignant obstructions of the ducts are most discouraging. They present themselves as emaciated, feeble subjects, generally worn out from prolonged ieterus, anæmia and poor digestion, with no resisting power left. Those that do not die shortly follow-

ing operation scarcely derive sufficient benefit to pay for the risk and suffering incident to the operation. A few early cases are no doubt benefited by an early cholecystectomy, done for the removal of a suspicious, thick-walled and useless gall-bladder. The consensus of opinion today is that cholecystostomy is the operation of choice, where the gall-stone disease is limited to the gall-bladder; it is infinitely safer and at the same time provides for better drainage of the biliary tract than when extirpation of the gall-bladder is done.

The gall-bladder is no longer looked upon as an absolutely useless organ, as is the appendix, to be removed in all cases, as one does the latter organ. The chief conditions calling for its removal, however, being cystic gall-bladders, with stone impaction in the systic duct; when these are to be removed acutely infected gall-bladders and possibly gangrenous, with necrosis of adjacent liver structure and local peritonitis, an extirpation had better be done. Chronic infections, with thick-walled gall-bladders should come away: they are useless and dangerous, in that they possibly give rise to malignant disease.

In my list of cases of gall-bladder surgery, now amounting to 47, there have been 12 consecutive cholecystectomies without a death. In cases of cholelithiasis, confined entirely to the gall-bladder, either associated with empyema and peri-cholecystitis, with abscess formation within and without the gall-bladder, my mortality likewise has been nil. The only deaths in this series of cases have been due—one from cholangitis following a common duct operation (this occurred six weeks after operation, and is the only common duct case I have lost), and the other deaths were cases, one due to hemorrhage a week following operation, and the only other deaths have been in malignant cases.

Time will not permit my going into the brilliant advances that have been achieved in gastric surgery. The recent progress along these lines is largely due to the magnificent work of Mikulicz, Mayo Robson and the Mayo Brothers of this country. The vast majority of stomach work, in fact three-fourths of the stomach surgery, is done for the relief of gastric ulcers, their sequellæ and complications. The consensus of opinion still is that acute gastric ulcers are essentially medical. The complications, such as perforation, cicatrical contractions and obstruction, hemorrhage and chronic gastric ulcer, are the principal indications for surgical interference. In acute perforations of the stomach the mortality is still high; as given by Blake, the mortality among the cases operated upon within 12 hours for perforation, was 39 per cent.; between 12 and 24 hours, 76 per cent.; over 24 hours, 87 per cent.

This shows that the time element is an important one.

Cicatrical Contraction and Obstructions.—These contractions occur almost invariably at the pyloris, and surgery here has given brilliant results, either by a Heineke-Mikulicz pyloroplasty, or by other methods, of opening at pylorus or a gastro-enterostomy. Gastro-enterostomy seems to be the operation of choice, although in my work I have had some excellent results following the Heineke-Mikulicz pyloroplasty. For this the mortality is not high, and in many hands not greater than in interval appendix operation.

Hemorrhage.—Hemorrhage from gastric ulcer is another proposition, and the results obtained by surgical intervention are not brilliant.

Jos. A. Blake, in his article on the surgical treatment of gastric ulcer, in the *American Journal of Medical Sciences*, states his opinion: "That a single large hemorrhage without previous symptoms referrable to ulcer should not be operated upon, but when there have been antecedent symptoms operation should be performed," also, that "cases suffering from recurrent hemorrhage should be operated upon."

The operation of choice here seems to be a gastro-enterostomy.

Chronic Gastric Ulcer.—This, unlike the acute gastric ulcer, is unquestionably best treated by surgical intervention, not by excising the ulcer, which would seem the operation of choice, but by doing a gastro-enterostomy and in this way giving good gastric drainage and side-tracking off the inflamed area. The excision of gastric ulcers seems to be not thought well of.

There is another class of stomach cases that I think surgery is going to be of great help to, and it is those cases of long standing chronic dyspepsia, without ulcer, by giving to them a large and low outlet to the stomach. It gives them a good gastric drainage and brings about most promising results.

I have had several such cases, the results of each being most pleasing.

In closing, I would say that I think the profession may look upon the surgical achievements in

the upper abdomen with pardonable pride, for it has shed more lustre and light than has been done in any other domain in the course of time.

REMARKS ON THE EPIDEMIC OF YELLOW FEVER IN BALTIMORE.

By James Carroll, M.D.,

Surgeon U. S. A., Washington, D. C.

Mr. President and Gentlemen of the Alumni Association:

Instead of a strictly technical theme, I have chosen one that may be of more general interest, and which formerly demanded the attention of two of the most brilliant minds among the early teachers of the University.

Dr. Nathaniel Potter, a former pupil of Dr. Benjamin Rush, and afterwards the first professor of theory and practice of medicine in the University, held in 1793, that yellow fever was not contagious, and he communicated this opinion to Dr. Rush in writing. According to his own statement, he believed that he was the only person in America who held that opinion, and in 1795 he prepared to defend his belief in an inaugural thesis to be read at the next commencement of the University of Pennsylvania of which he was a student. He was dissuaded by Dr. Wistar on the grounds of propriety and expediency. Dr. Potter states that in 1797 Rush's contention that the disease was contagious was first publicly attacked by Dr. John B. Davidge, one of the founders and the first professor of surgery and obstetrics in this school, whose paper was published in the *Federal Gazette*, of Baltimore, on the 30th day of November, 1797. Dr. Davidge subsequently enlarged his paper and embodied it in a volume entitled "Physical Sketches," published in Baltimore in 1814. On account of the importance of this city as a seaport, in almost constant intercourse with the West Indies, yellow fever must have been introduced a great many times, yet the only important epidemic outbreaks of the disease took place in 1794, 1797, 1800 and 1819. It is notable that all the outbreaks began at Locust Point, or about the docks and wharves, and they can be traced directly or indirectly to the shipping. The relatively high ground upon which the city stood, and the distance from the city proper to the wharves and shipping, explain why the interurban residents suffered but little, while those living upon the poorly drained, low-lying districts near the river were compelled on such occasions to flee for safety. It can be easily shown that yellow fever was frequently confounded with malaria; indeed, it was strongly contended that the two diseases were one and the same, the difference being only in the degree of intensity. Then, while many contended that the disease was imported, and though their contentions could be supported by sworn testimony, there were others among the leaders and teachers in the profession who held, with Rush, that since the infection was most prevalent in poorly drained localities, the water and decomposing vegetable matter must be necessary for the generation of the poison, which was manifestly conveyed through the atmosphere. The general restriction of the disease to the localities described, the observation that many persons who visited those localities for only a few hours became infected, while in other localities no infection took place, even among those who were intimately associated with the patients, proved the disease to be one of locality. With the observation that if the wind blew strongly from the direction of the infected locality toward the city, that within a few days the disease also extended toward the city, it was concluded, with reason, that the poison must exist in the atmosphere, that it was transported by the winds, and that infection could only result from the inhalation of this poison, which was believed to be gaseous in nature. This agreed with Sydenham's theory of the epidemic constitution of the atmosphere, which was supported by Rush and his pupils, and which then seemed to offer the only explanation of the recorded observations of centuries. If we admit the mosquito as the sole carrier of the disease, we will be prepared to acknowledge that their observations were, in the main points, strictly accurate; that their reasoning was logical, and the deductions fully justified by the premises. It then becomes very easy to understand how the disease became one of lowly situated and poorly drained localities; how it was transmitted by the atmosphere; how it failed to spread in certain locations, and how it disappeared upon the appearance of a heavy frost. The observation was actually recorded by a Baltimore physician, that during the epidemic, mosquitoes became an intolerable pest, while but a short time before no mosquitoes were observed. How beautifully this observation

agrees with our present knowledge that the yellow-fever-carrying mosquitoes can be conveyed on vessels; that in the warmer season of the year they will multiply on shore, gradually extending from house to house, breeding in and about the dwellings (for they are domesticated insects), and that they become infected only after feeding upon a patient. The importation of the mosquito explains the appearance of this insect in places where it usually does not exist; it explains the occurrence of the earlier cases among persons who either visited the vessels or wharves or docks, or who lived in the vicinity of them. It also explains why favorable localities were visited by the infection only, as a rule, when they received shipping: while localities equally favorable to the infection, but far from the shipping, remained free from it. Of course, the absence of the proper mosquito explains the failure of the disease to spread to any extent in the city proper. This stood upon ground that was high and dry, and it was at that time some distance from Fell's Point, the location of Sugar House Wharf, where many of the vessels from the West Indies probably made their landing. Assuming that at the Sugar House Wharf, cargoes of sugar were unloaded, we are reminded that sugar is a favorite food for the yellow-fever-mosquito, and that it can subsist on this and water alone for months. Now Sugar House Wharf was at Fell's Point, and most of the outbreaks began at Fell's Point, where, presumably, the largest number of mosquitoes was imported.

During the epidemic of 1794, 360 deaths were recorded. Dr. Drysdale reported[1] that he saw his first case just before death on the 7th of August, at Bowley's Wharf, in the town, and on the 14th, 20th, 22d and 23d of the same month he saw five additional cases at the same part of the wharf. There were also at the same place some other cases which did not come under his care. Dr. Drysdale states that there was considerable sickness at Fell's Point after the death of his first case, and many deaths had occurred suddenly, or after a short indisposition. An investigation was made by three of the most respectable physicians, who reported that the prevailing fever was the common epidemic of the season which visited the Southern and Middle States annually, viz.: the bilious remittent fever. The number of cases now rapidly increased, so that by September 25, in about seven weeks, five physicians were attacked and two of them died. The cases had become so numerous that Dr. Coulter visited and prescribed for more than 120 persons daily. By the end of the month many families had sought refuge in the country. During this time the city remained unusually healthy, and although some persons infected at the Point died in the city proper, in that location the disease failed to spread.

In his ninth letter of a series to Dr. Rush he states that yellow fever was first discovered at two points, remote from each other, viz.: at Bowley's Wharf in the town, and at Fell's Point. Many cases occurred throughout the town, but these originated either from communication with Bowley's Wharf or the Point, and the infection could be distinctly traced to one of those two places. Being puzzled to explain why the infection was confined to those two places, he found that the first cases on the Point were confined to houses whose cellars were filled with stagnant, putrid water, and he also found black, putrid and offensive water beneath the stores in which the sick resided at Bowley's Wharf. Almost all those who were first affected were new-comers. Dr. Drysdale describes the Point as being low and flat; its streets generally not paved; its alleys filthy and the ground around it marshy in many places. The frequent warm rains kept the noxious places constantly moist under a hot sun. We can easily recognize these as conditions favorable to the multiplication of mosquitoes, and the domestic habits of the *stegomyia* mosquito would tend to keep the infection rather closely confined to these localities. He further makes the significant statement that remittents were present from a very early period. It is more than probable that many of these remittents were true yellow fever, because under the belief then prevailing, that these were simply the prevailing types of summer fever, they would not be reported. It is also probable that if occasional cases were known to have been yellow fever, some physicians would have concealed them from the same motives that prevail today. He could discover no satisfactory evidence of the importation of the disease, though he states that the "Triumph" arrived at the wharf about the last of June, with almost all the crew indisposed, and previously to this there lay at the wharf a schooner whose captain had died on the voyage from the West Indies. The fact alone, however, that ves-

[1] *The Philadelphia Medical Museum*, 1805, 1 26. Letters written by Dr. Drysdale to Dr. Rush.

sels from the West Indies came up to the wharf is sufficient to indicate to us the source from which the infection was received. The following sentence toward the end of the ninth letter is of extreme interest: "Locusts were not more numerous in the reign of Pharaoh than *mosquitoes through the last few months:* yet these insects were very rare only a few years past, when a far greater portion of Baltimore was a marsh." With wonderful acuteness of observation he remarks that some families at the Point avoided yellow fever by carefully precluding all communication with the sick, and that vessels also preserved their crews in health by removing to a distance from the wharf and preventing the sailors from going ashore. As soon as one infected person came on board he quickly infected all or most of the crew. He instances one man who contracted the disease on shore and carried it on board the ship "Phoenix," whose crew was healthy. These all became infected and five out of twelve died. As the result of these observations he very naturally concluded that in some instances the fever proved contagious. These, and other cases cited, are now so easily explained by the mosquito theory that we cannot appreciate the perplexity of the problem as it formerly presented itself for solution. The most accurate and careful observation yielded results that were apparently contradictory. All honor to Dr. Drysdale, whose tenth and last letter of the series was written to Dr. Rush in December, 1794.

Some further interesting references to this epidemic were published by Dr. John B. Davidge in 1798 and subsequently rewritten by him in a treatise on yellow fever, published in 1813. He makes the interesting statement that the yellow fever first appeared in the last of August, but the common bilious fever prevailed at Fell's Point from June. A lady from Philadelphia was attacked with yellow fever, on Charles street, and she had black vomit, but no other person in the family or neighborhood was attacked during the whole season. He noted that the disease extended in the direction of the prevailing winds, and that it was conveyed by a northeast wind all along Federal Hill and the west end of the basin. A considerable number of cases occurred in the city and many who had attended the launching of a frigate (near the water, of course), subsequently suffered from yellow fever, and several of them died, but no single person in the city contracted the disease from them.

Concerning the prevalence of yellow fever in Baltimore at that time (1798), Dr. Davidge writes, "A physician in conversation the other day told me that he had met with the yellow fever, in Baltimore, ever since he had lived in it, which is fifteen or twenty years. It is violating all obligations of decency and truth to say that it is of recent date." This statement was probably correct, for every importation of the disease is not necessarily followed by an epidemic. In Baltimore and other places where the mosquito, *stegomyia fasciata*, is not normally present, an epidemic is not possible, after the introduction of any number of cases, provided the mosquito be absent. For the production of an epidemic the introduction of infected mosquitoes alone during the hot season may suffice, because the mosquitoes deposit their eggs, and in a week or ten days another brood will have become mature. The insects of this new brood must bite a patient in the first three or four days of the attack in order that they may become infected. Should only one or two infected insects be brought in and should they die (as frequently happens) immediately after depositing their eggs, then the disease would appear only in the persons first bitten by them, and these would have passed beyond the infective period by the time the new brood had matured. Should the infected insects, however, have remained alive, and should they have bitten other persons, at intervals of a few days in succession, these persons would be in the proper stage of the disease at the maturing of the new brood to enable them to become infected. When the proper mosquito has been previously introduced into a favorable locality in the proper season, or when the mosquito, *stegomyia fasciata*, is naturally present, the introduction subsequently of a single case, may produce an epidemic. The facts above stated will readily explain the frequently reported appearance of sporadic cases without the occurrence of secondary ones.

We can now see that the immunity against the disease enjoyed by the city proper evidently depended upon its high and dry location, which rendered the conditions unfavorable for the multiplication of the mosquitoes that were imported. In this regard Baltimore was more fortunate than Philadelphia, which was lower and contained more standing water. Hence, the mosquitoes

were more abundant and the disease spread uniformly. This led Dr. Rush to contend that the disease must be contagious, while Dr. Davidge held that the contagion was local, and existed only in the air of certain spots, from where it might be wafted by the winds in any direction. Dr. Davidge asserted (p. 84) that they had the most stubborn and irrefragable proofs, in those cases occurring about the wharves and at Fell's Point, that the disease was incapable of supporting itself. When these cases were removed up into the city their virulence died with them, those who died; and, he writes, "from those who recovered, all mischief and supposed contagion evanesced into empty air, which bore it to the pages of medical writers, and not to the bodies of healthy attendants. This was the result in 1794 and 1797."

The importance of this observation can hardly be overestimated; it shows the sagacity and care with which the epidemic was studied by these devoted men. Dr. Davidge learned the truth, and that truth unfortunately still remains today a hidden mystery to many of our practitioners, notwithstanding the recent absolute demonstration of it beyond a shadow of a doubt.

In connection with the now known mosquito propagation of the disease, an observation recorded by Dr. Nathaniel Potter[2] in this outbreak of 1797 deserves mention. He tells us that previous to the 17th of September the fever had been confined to certain places and to such as had breathed the air evolved from them; on that day a strong southeast wind wafted the affluvia in a northwest direction, and diffused it among the inhabitants of the upper parts of Frederick, Gay, South and Calvert streets, who became immediately implicated in all the horrors of the fever.

In 1800 there appeared the severest outbreak the city has known. The mortality from yellow fever is recorded to have been 1,197, or about one in fifty of the population of 60,000. Again the disease began at Fell's Point, on the borders of the Cove, which extended from Jones' Falls to the interior. The Faculty of Medicine of the city, after investigation, reported to the Mayor that in their belief the disease was not imported, but originated in the Cove from the stagnation and putrefaction of filth under a summer's sun. The first two cases appeared on the 2d of May[1], another on the 8th of June, one on the 9th, 10th and 13th; then from the 22d they became more numerous It is unfortunate that we have no detailed description of this epidemic, the most disastrous the city has ever experienced.

A few cases are reported for the years 1802-1805.

The next important outbreak took place in 1819 following the arrival of an infected ship from Havana.[2] In a letter to the editors of the *Medical Repository,* Dr. Pierre Chatard,[3] of Baltimore, writing October 19, cites the first cases as follows: The fever commenced raging at Fell's Point in the beginning of July, and never ceased there until the end of October. It appeared also at Smith's Dock toward the end of July, carrying off five persons, whose names are given, and others. The persons named had counting houses on the dock or in the vicinity. No other cases appeared at the dock for two months, at the end of which time two more appeared. Dr. Chatard attributes the absence of cases during this time to the great quantity of lime that had been strewn on the ground by order of the Mayor. The lime was again applied and the cases ceased. At Fell's Point the disease raged for three months before it subsided. The greater part of the population retired to the healthier portions of the city, and many of them sickened and died there, but none of their friends or relatives suffered in consequence. We are told by Dr. Chatard that the epidemic focus on the Point never exceeded seven or eight thousand square feet. This information he regarded as precious because it demonstrated the non-contagiousness of the disease and the value of a local quarantine.

Among the most interesting records of this epidemic are the letters and other documents published by authority of the Mayor in 1820. These contain the actual opinion and experiences of the physicians, and they show a remarkable unanimity in the belief among the Baltimore physicians that the disease was non-contagious. The persistency with which the infection originated and remained in the vicinity of shipping, wharves, etc., is generally commented on. Dr. Clendinen reports that his first cases were located at the southeast corner of Fell's Point, and several of them appeared among foreigners on board the

[2] *Memoir on Contagion,* by Nathaniel Potter, M. D., Baltimore, 1818, p. 20.

[1] *Medical Repository,* New York, 1801, Vol. IV, p. 351.

[2] *Carpenter on Yellow Fever,* New Orleans, 1844, p. 18.

[3] *Medical Reoository,* New York, Vol. 20, 1820, p. 261.

shipping, persons who had been healthy previous to their arrival. This invasion by the disease of healthy ships tied up to the wharves appeared to be indisputable evidence of the poisoned condition of the atmosphere. Of course, it is hardly necessary to say here that these vessels were simply invaded by infected mosquitoes. Dr. Clendinen was a resident of the Point, and he states that his family had suffered from the disease and he had lost a student, an assistant physician, and some of his best friends. Dr. Samuel B. Martin, after enumerating 34 of his earlier cases, with their location about the wharves and shipyards, states: "These will suffice, I think, to show the course the disease took in its commencement, traveling regularly along the course of the water and infecting the streets in the vicinity thereof. My most violent cases were near the water's edge or contracted there."

No mention of this epidemic would be complete without a reference to the little book by Dr. David M. Reese, entitled "Observations on the Epidemic of 1819," a book which everyone interested in the subject should read. According to him, some persons attributed the epidemic to the arrival of the schooner "Adventure" from the West Indies, laden with coffee, while others looked with suspicious eyes upon the schooner "Proserpine," laden with hides and coffee. Both vessels were ordered to the quarantine ground, but were soon permitted to return because, after a re-examination by the health officer, their cargoes were found to be in a sound condition.

Referring to the time when 1,016 cases had been reported by the physicians, Dr. Reese states that of all of these only twelve were supposed to have originated in the city. He calls attention to the remarkable fact that, in almost every instance where a person visited the Point at night they contracted the disease, while those who were there only in the daytime escaped with impunity. He further remarks that those of the Baltimore physicians who became infected suffered in consequence of paying a visit by night to the source of infection, or to the vicinity where the cause existed. Several physicians who had attended patients in the daytime in the very center of the infection, and through the whole course of the fever remained exempt, until by visiting the district once in the night they contracted the disease. This accords perfectly with the mosquito theory and with the twilight habits of *stegomyia fasciata*, the particular mosquito now known to be concerned in the transmission of the disease. It is also in accord with the experience of the American troops near Havana. Soldiers who visited the city only between the hours of 9 A. M. and 4 P. M. remained free from the disease, while among those who became infected there were but few who did not acknowledge having spent a night or a part of a night out of the barrack. Let us now consider what evidence, if any, collected by these closely observant Baltimore physicians could be used to support the mosquito theory today. Firstly, they recorded the presence of an unusually large number of mosquitoes; secondly they observed that the infection was localized in the low, wet districts near the river and shipping; thirdly, they noted that the infection was contracted mostly at night; fourthly, they showed that in the higher and drier ground of the city proper the disease was absolutely non-contagious; fifthly, they reported that the disease traveled in the direction of the prevailing winds, when these were strong and blew in one direction; and, sixthly, they were familiar with the fact that yellow fever was most apt to prevail when the mean temperature was high, and they knew perfectly well that the disease was stamped out by the frost. To this we can add nothing more than the direct implication of the mosquito. Of course, a mistake was made in the failure to recognize the imported nature of the disease, and strong protests were written against the quarantine methods then in force against Baltimore by Philadelphia, Wilmington and other places. These quarantines were established in the belief that the disease was contagious. The Baltimore physicians, having the strongest proofs that it was not, felt that they were treated with undue severity. In a low-lying city like Philadelphia, where mosquitoes were numerous, there was justification for the belief in contagion, so that, while both were partly wrong in their opinions, under the circumstances the method of quarantine was a justifiable and proper one to adopt for their safety. On the other hand, the lax quarantine system at Baltimore was a source of danger, still it was justifiable on the ground of the available evidence to show that yellow fever was not contagious and upon the belief then prevailing that all infectious fevers were the result of putrefaction. Hence, if a vessel were clean and her cargo in good condition, it was assumed that she

could not harbor the seeds of the disease and she was permitted to come into dock and unload.

In the management of the epidemic the wise policy was adopted of advising all persons to flee the infected location and seek a residence upon high ground without the range of the infection. This the majority did, many going to the country or remaining nearby, while some refused to leave their habitations, and these latter furnished the fuel for the continuance of the pestilence. This epidemic is said to have cost the city 350 lives.

The kindly concern shown for the welfare of the destitute poor stands out brightly in the history of this outbreak. It became necessary to remove the healthy poor from Fell's Point and provide means of shelter and sustenance for them until it was safe for them to return. A committee was appointed who visited a Mr. Owen Dorsey to solicit the use of a ropewalk owned by him. This was granted free of charge and the removal began. More room was soon needed, and a Mr. Christopher Chapman gave up another adjacent ropewalk, 1,000 feet long, for the purpose. This was not sufficient and more than 100 tents and marquees were then pitched and filled. Over 1,000 persons were received, made comfortable and supplied with provisions and every necessity. The corporation appropriated $1,000, but this was returned, the donations of money and supplies being ample for all purposes. Notwithstanding the partial depopulation, business depression, failure of some of the leading commercial houses and one of the banks, over $1,000 in cash were contributed and liberal donations of food, clothing, etc., poured into the warehouses designated to receive them. The neighboring farmers contributed flour, fruit and vegetables, as well as money, and Georgetown, D. C., contributed $700. A soup-house was established at the encampment, and this supplied over 100 gallons of rich, wholesome soup daily. This enterprise was undertaken by three energetic gentlemen—Messrs. Stewart, Mosher and Coale—and through voluntary contributions of material and labor the total outlay required was only $10. The camp was maintained for 53 days, and when it was broken up, on the 25th day of October, each person was supplied with provisions for three days. There were only six deaths in the encampment and five additional in the hospital of persons who contracted the fever at the Point and were carried from the camp to the hospital for treatment. The sick among the poor were cared for at the hospital at the expense of the city. Food, luxuries and stimulants were provided for distribution upon the order of any practicing physician. It is estimated that by these means several hundred lives were saved and the record is one of which Baltimore should be proud. The Mayor, Edward Johnson, was a man of Christian character, high courage and strong determination. Disregarding protests the Mayor and many of the Board of Health visited the hospitals during the height of the epidemic, and by their example inspired others with confidence in the non-contagious nature of the disease. Dr. Reese wrote of him: "Mr. Johnson is one of the few individuals with whom, when *interest* and *duty* are in opposite scales, the latter will ever predominate."

After this disastrous epidemic a few cases occurred annually until 1805, and perhaps later.

Ten cases are reported to have appeared at Fort McHenry in 1868, and the disease was believed to come from infected vessels in quarantine nearby. It is probable, as has been stated by Dr. John Morris,[1] that sporadic outbreaks were frequent at Fell's Point until 1855. In this year Dr. Kemp, of the Board of Health, had the infected district drained and cleaned. It is said to have been free from the disease from then until 1876 (except during the suspension of commerce during the Civil War), when a small outbreak of the fever undoubtedly appeared, though the cases were not officially reported.[2]

In this review of the epidemics at Baltimore, the literature of which is very scant, I have confined myself to a simple narration of the facts which seem to be of general interest, and I hope that some of you may be stimulated to read for yourselves the records written by men of this city, some of whom were teachers in our University and of whom you have every reason to be proud.

[1] *History of the Epidemic in Baltimore in 1876. Reports of American Public Health Association*, Vol. IV, p. 244.

[2] *Baltimore Physician and Surgeon*, Vol. VI, No. 2, 1876, p. 37.

The management of the Baltimore General Dispensary held the 106th annual meeting of the organization, Thursday, January 18, 1906, and elected Dr. Edward MacKenzie, class of 1884, one of the physicians to the institution.

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EDITORIAL

THE ORGANIZATION OF AN ALUMNI ASSOCIATION OF THE UNIVERSITY IN NORTH CAROLINA.—It has been suggested by one of the most promising and active of the younger alumni of the University residing in North Carolina—Dr. J. L. Hanes, of Winston-Salem—that the forthcoming meeting of the State Medical Society, in Charlotte, would be a suitable occasion to organize an association of alumni of the University residing in that State. At these annual meetings of the State Society the University is largely represented, and it would be no difficult undertaking to organize an association that would be a great advantage to the University as well as of value to the alumni. Next to the State of Maryland, North Carolina sends annually to the University the largest number of students. Not only in numbers, but in quality and character of material the University has a right to feel proud of the patronage which comes to her from the Old North State. As a student body and as practitioners of medicine the North Carolinians are a loyal, manly and energetic lot of men, and do full credit to the University and to their State on all occasions. They measure up to the highest standards as students, and after graduation return to their homes to become the leading physicians and citizens of their State. The University of Maryland has at this time between three hundred and four hundred of her graduates living in North Carolina, widely scattered over her territory from mountain to seacoast, and wherever located are in the front rank. The loyalty of these alumni to the University is shown in many ways. They have kept alive the very best traditions of their alma mater by the high standards they have made for themselves and by the support they have given to every advance the University has made. It is eminently important that these alumni of the University should organize a State Alumni Association in which they can come together to strengthen the ties of brotherhood, which should exist between graduates of the same institution, and to foster purposes which will be advantageous both to the University and to her alumni. If this work of organizing an Alumni Association is taken up by some of our representative alumni in the State, we have no doubt that a successful result will be accomplished.

CLOSE OF VOLUME I OF THE BULLETIN.—With the present issue, the BULLETIN completes its first volume. Whatever doubts the promoters of the BULLETIN may have had of its success in the beginning of its career, these doubts have been removed by the present conditions of its prosperity From month to month it has appeared on time, and has presented visible evidence of a substantial growth and improved condition. The purpose which called it into existence has been forwarded to the best of its ability. It has aimed to be a representative organ of the Medical Department of the University of Maryland and of the alumni of this department. In its columns it has tried to publish matter that was instructive as well as entertaining and pleasing to the alumni of the University. Whilst not up to the highest standard of scientific and literary excellence, it has aimed to be respectable and useful, newsy as well as instructive.

During the year copies have been mailed to every alumnus whose postoffice address was known, and personal mention has been made of the alumni whenever possible or whenever an occasion called for notice. It has been simply impossible to reach every alumnus or to refer to all in a personal way, but no one has been overlooked intentionally. In subsequent issues the BULLETIN hopes to reach every graduate of the University and to bring his name and work to the notice of his old classmates.

Whilst the BULLETIN has been cordially received and patronized by a large number of the alumni, it has one complaint to make, which reflects more upon the alumni than upon the BULLETIN. We refer to the indifference which many manifest in contributing to the reading matter and to the personal notices which make up its pages. The request has been made for such con-

tributions, and the fact that they do not appear is an indication that they have not been contributed. Short original articles, reports of cases, letters, and personal references from old students, would add greatly to the interest and value of the work the BULLETIN is trying to do for its readers. When it is borne in mind that the BULLETIN occupies a field in journalism different from that of the ordinary medical journal, that its claim to support is based upon personal grounds and in deference to a sentiment, we feel that it should be encouraged by every alumnus who has a loyal regard for the old University. Having demonstrated its right to a place in the list of periodicals, the BULLETIN enters upon its second year with hopeful signs of a long and useful life. As it grows in age and experience it expects to improve in quality and influence. New features will be added, new matter will be published, and everything will be done as far as is possible to widen the scope of its usefulness and interest to all of its readers.

POST-GRADUATE WORK AT THE UNIVERSITY.—The opinion has been repeatedly expressed in University circles that a definite post-graduate course of instruction should be organized. The BULLETIN has called attention more than once to the fact that while no definite course had been organized by the faculty, post-graduate instruction was practically given in many departments at little expense to the student. In the departments of anatomy, pathology and in the laboratory of clinical medicine, any graduate can secure a special training upon application to the heads of those departments. In clinical medicine and surgery, both in the Hospital and Dispensary, the graduate can make his own terms, for this work is practically open to everyone who expresses a desire to profit by an attendance. The greatest amount of liberty has been given to former graduates who visit the University or Hospital. All are invited to come and see what is going on in the clinical and laboratory work of the school. Many have taken advantage of this opportunity, and it is gratifying to the faculty to see the number of old students around the University increasing. It is true that many drop in only for a day or two, but the number making longer visits is gradually increasing from month to month. That those in attendance are profited by these short or long visits to the University, each one must testify for himself, but we do not hesitate to affirm that every physician who will keep himself in personal touch with the work now going on in various hospitals will be improved in his work by this contact, however brief it may be. Hence we say to all graduates, living both far and near, that an occasional visit to the Hospital or to the University will be profitable and we hope agreeable to all. Come and see what is being done, stay as long as may be agreeable, ask to see what is not in sight, and we feel assured the visit will prove in the long run to be a satisfactory one. The University extends a cordial welcome to every alumnus who visits her walls with a feeling that he is a part of her and has a claim upon her affections and interest.

ABSTRACTS AND EXTRACTS.

NEW EDITION OF PHARMACOPŒIA.

At the meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital on November 21, 1905, addresses were delivered by Professor Charles Caspari, Jr., of the Pharmaceutical Department, and by Professor Charles W. Mitchell.

Dr. Caspari spoke upon the very important subject, "The New Edition of the United States Pharmacopœia," dealing especially with the change of method in the standardization of drugs, and the underlying reasons necessitating such a radical departure, together with a few introductory remarks concerning its origin. Originating in the medical profession during the Revolutionary War in the year 1781, for many decades to come physicians guided its career. The first edition, which was compiled and edited by Dr. William Brown, of the Continental Army, was more of a formulary intended for the guidance of the army surgeon in the treatment and care of soldiers. The only copy, written entirely in Latin, now in existence is at present deposited in the office of the Surgeon-General at Washington, D. C. In 1810 a convention of physicians met in the National Capital under the directorship of Dr. Mitchell for the purpose of establishing a true pharmacopœia, as until this time they were compelled to resort to the British and foreign pharmacopœias for their guidance. Ten years later this edition was revised, and in 1840 another edition was issued. It was not until 1850 that phar-

macists were invited to participate in the conventions, and at the present day manufacturing chemists have a voice in the editing of the book. Not only are physicians the progenitors of the pharmacopœia but the revision of a certain portion of the book is left entirely to physicians, namely, the therapeutic committee, and nothing is added to or abstracted from its contents unless approved by this committee. Thus, as formerly, physicians are responsible for the matter entering the pharmacopœia. In the new pharmacopœia the average doses are given, instead of a maximum or a minimum, and by way of apology the speaker informs us this is due to the special direction of the therapeutic committee. The chief point of interest to physicians, however, is the great number of changes incorporated in this edition, viz., the new method of standardization, *i. e.*, the amount of alkaloidal principle being the guide to its quality, or composition, instead of as formerly basing the purity of the remedy upon the amount of the crude drug the preparation contained. In the tincture of belladonna there must be a definite quantity of the alkaloidal principle present before the drug comes up to commercial requirements, likewise with all the other tinctures. Consequently, the active constituent will always be the same in amount, no matter whether the drug is prepared from the very poorest crude materials. It has, moreover, been the endeavor of those concerned with the revision to approximate the strengths of all the extracts and fluid extracts as closely as possible, in order to unify and simplify matters. There were 174 changes in this edition, 121 additions and 151 eliminations. The new standard cannot be applied to all drugs, to wit, digitalis, ergot, cannabis indica, strophanthus; so the method of their preparation was not molested. The physiological test of digitalis is the only index to its efficiency upon which we can place any dependence, as its alkaloids are too complex and unstable to be employed as a unit for standardizing its preparations. There are a few changes in the names of drugs—the well-known drug catechu is no longer in the pharmacopœia, but is now recognized under the name of gambia. Patent and proprietary medicines have come in for their share of attack, and those whose patents have not expired, and physicians insist upon having them incorporated in the book, the editors have tried to accommodate, but they have declined to give the drugs the proprietary names, but employ the chemical phraseology, for instance, phenacetine may be dispensed under the name of acetphenetidin, sulphonal as sulphonmethane, trional as sulphonethylmethane; carbolic acid is now known as phenol, in order to distinguish it from the crude product. Antiphlogistine may be prescribed as cataplasme kaolini. All these changes were introduced in the endeavor to bring uniformity in prescribing and for the sake of cleaner and purer pharmacy. It is to be hoped that physicians will inform themselves of these changes, and will discontinue the use of proprietary remedies. It must be thoroughly understood, however, that these new remedies cannot take the place of the proprietary medicines when the latter are called for in a prescription. The new names also serve the excellent purpose of confusing the patients, and they do not know what they are taking. Not only are the tinctures, but also are the solid and fluid extracts, standardized according to the new method. In those cases in which an alkaloid is wanting, a definite amount of the crude drug is still used as the standard. It is extremely desirable that the drugs of the English-speaking nation shall be of the same strength, especially when they are employed for scientific purposes. The new pharmacopœia is not a treatise on therapeutics, but a book of standards.

In his address, "The Therapeutic Aspect of the New Pharmacopœia," Dr. Mitchell delivered an impassioned appeal to those present, as well as to all physicians and students of medicine, to acquaint themselves with the alteration in the latest edition of the U. S. P., so that the prescribing of proprietary and patent nostrums shall be a memory of the past. Consumed by the fever for the specialties in the past few decades, students and practitioners have sadly neglected to perfect themselves in the important subjects of materia medica and pharmacy, consequently losing the art of prescribing and laying themselves open to the insolence of proprietary and patent medicine venders. The attention of the society was also called to the union that the patent medicine manufacturers have formed for their protection, and to the method of disposing of cheap alcoholic beverages without the payment of the internal revenue tax, under the guise of medicine.

Dr. Louis McLane Tiffany has left Baltimore for Florida upon an extended hunting and fishing trip.

NOTES AND ITEMS

Dr. Cooper Drewry, class of 1903, sailed January 9,, 1906, for the Mediterranean, and will spend several months abroad.

Dr. St. Clair Spruill, who has been very ill from septicemia, due to an infected finger, we are glad to report, is out of danger.

Miss Mena Shipley, one of the first graduates of our training school, is superintendent of nurses at Moore Hospital, Eveleth, Minnesota.

The wife of Dr. F. F. Brooks, class of 1900, New Windsor, who has been ill at the University Hospital, has recovered and returned home.

Miss Sophie Featherstone, graduate nurse, class of 1900, has been appointed superintendent of nurses at Franklin Square Hospital, Baltimore, Maryland.

Dr. Daniel Jenifer, class of 1904, who has been an interne in a hospital at Atlantic City, has associated himself with Dr. H. B. Stevenson, of Sherwood, Baltimore county, Maryland.

Mr. and Mrs. John W. Pyle have announced the engagement of their daughter, Elizabeth, to Dr. James R. Bishop, class of 1904, of Nanticoke, Md. The wedding will be solemnized in April.

Dr. H. O. Reik, class of 1891, was present at the convention of the Southern Branch of the American Laryngological, Rhinogological and Otological Society, held at Norfolk, January 13, 1906.

First-Lieutenant Gideon McD. VanPoole, class of 1899, assistant surgeon U. S. A., having been relieved from duty at Cuartel Meisic, Luzon, will proceed to Camp McGrath, Batangas, Philippine Islands, for duty.

Dr. and Mrs. E. M. Duncan celebrated the 20th anniversary of their marriage at their home, on the York road, Govanstown, Saturday, January 19, 1906. Dr. Duncan is a graduate of the University of Maryland, class of 1884.

February 2, 1906, in a game of basketball at the Cross Street Hall, the University of Maryland team beat the Gettysburg represenattives 42 to 27, and during the latter part of January the Maryland Agricultural College aggregation 10 to 8.

Dr. Julian W. Ashby, class of 1905; Dr. W. C. Linville, class of 1903; Dr. W. W. Craven, class of 1903; Dr. A. D. Edwards, class of 1903, have been appointed contract surgeons to the South and Western Railroad and are located at Spruce Pine, N. C.

In a game of basketball at the gymnasium of the Baltimore Athletic Club, January 20, 1906, the team of the University of Maryland was defeated by the five representing that organization by the score of 18 to 6. The University men showed the effect of lack of training in their team work, but they have the nucleus of a formidable aggregation, and with a little more practice should give a good account of themselves.

At the annual election of officers of the Baltimore Medical and Surgical Association, held January 8, 1906, the following of our alumni were elected to office: President, Dr. A. C. Harrison, class of 1887; first vice-president, Dr. John T King, class of 1866; secretary, Dr. J. N. Reik, class of 1900; chairman of the executive committee, Dr. C. Urban Smith, class of 1889; upon the committee of honor, Dr. Randolph Winslow, class of 1873.

A committee from the Department of Medicine was recently before the finance committee of the Senate, urging them to favorably report a bill to the Legislature, requesting an appropriation of $100,000, which money will enable the faculty to add another wing to the Hospital and greatly relieve the cramped and overtaxed facilities of the present Hospital. Any alumnus who can aid in assuring the realization of the above-mentioned measure will be furthering the prestige and educational facilities of his alma mater.

Dr. Armfield F. Van Bibber, class of 1896, Belair, Maryland, has been appointed physician to the Harford county almshouse, and the following have been appointed vaccine physicians to the districts of Harford county prefixed to

their names: Second district, Dr. Jay H. Stier, class of 1886, Perryman; Third district, Dr I. Hall Richardson, class of 1891, Belair; Fifth district, Dr. Walter B. Kirk, class of 1893, Darlington. Dr. Frank P. Smithson, class of 1880, Forest Hill, has been appointed register of the Third district.

At the annual meeting of the Talbot County Medical Association, January 31, at Easton, the following list of our alumni were elected to the office prefixed to their name for the ensuing year: President, Dr. Julius A. Johnson, class of 1871, Easton, Md.; vice-president, Dr. Edward A. Trippe, class of 1862, of Easton, Md.; secretary-treasurer, Dr. Philip L. Travers, class of 1902, Easton, Md.; board of censors, Dr. Kennedy Wilson, class of 1873, of Tilghmans, Md.; Dr. Samuel C. Trippe, 1875, of Royal Oak, Md. After the election of officers an interesting address was delivered to the society by Dr. L. M. Allen, class of 1896, of Baltimore.

On Thursday, January 25, 1906, the General Alumni Association of the University, assembled in convention, elected the following officers for the ensuing year: President, Oregon Milton Dennis, LL. B. Secretary-Treasurer, Dr. Eugene F. Cordell, class of 1868. Executive Committee (Medical), Dr. Geo. Fleming, class of 1884; Dr. Charles E. Sadtler, class of 1873; Dr. G. Lane Taneyhill, Sr., class of 1865; Dr. F. D. Gavin, class of 1874; Dr. N. L. Dashiell, class of 1882. (Dental), Dr. Clarence J. Grieves, Dr. George L. Deichman, Dr. Herbert F. Gorgas, Dr. J. F. Koerner, Dr. F. W. Schoendorn. (Legal), Hon. Henry Stockbridge, Oregon Milton Dennis, LL. B.; John Leiper Winslow, LL. B.; Thomas B Marshall, Jr., LL. B.; Wm. B. Levy, LL. B. (Pharmaceutical), Henry Troxell, Ph. G.: J. Edwin Hengst, Ph. G.; L. Leroy Robinson, Ph. G.; Daniel Base, Ph. G.; W. A. Conway, Ph. G. Endowment Committee (Medical), Dr. Eugene F. Cordell, class of 1868; Dr. Wm. Whitridge, class of 1862; Dr. Wilmer Brinton, class of 1876; Dr. B. Merrill Hopkinson, class of 1885: Dr. J. Dawson Reeder, class of 1901. (Dental), Dr. L. Halpern, Dr. C. W. Himmler, Dr. F. J. S. Gorgas, Dr. J. F. Koerner, Dr. Clarence J. Grieves. (Legal), N. Winslow Williams, LL. B.; Hon. Henry Stockbridge, John L. V. Murphy, LL. B.; Charles Morris Howard, LL. B.; W. T. Brantly, LL. B. (Pharmaceutical), Henry P. Hyson, Ph. G.; J. F. Hancock, Ph. G.; John A. Morris, Ph. G.; Edwin Hengst, Ph. G.; Henry Troxell, Ph.G.

After the election of officers, a collation was served in honor of the guest of the evening, Dr. James Carroll, class of 1891, assistant surgeon U. S. A., one of our most distinguished alumni, professor of bacteriology in the George Washington University, Washington, D. C., curator of the Army Medical Museum, and the sole American survivor of that immortal Cuban Commission which discovered the mosquito to be the medium of conveyance of the contagion of yellow fever from an infected individual to a healthy being, read an interesting paper which is published in the present issue of the BULLETIN.

Among the visitors to the University Hospital during the past month were the following:

Dr. Marion King, class of 1899, a rising young practitioner of Texarkana, Texas.

Dr. Frank O. Miller, class of 1902, of Alberton, Maryland.

R. Clinton Bunting, M. D., class of 1900, of Wilmington, North Carolina.

Josephus A. Wright, M. D., class of 1881, Sharptown, Maryland.

Dr. A. J. Edwards, class of 1899, of Bristol, Virginia-Tennessee.

Capt. W. N. Bispham, class of 1897, assistant surgeon, U. S. A.

Dr. Hughlett Hardcastle, class of 1895, of Easton, Maryland.

Dr. William Russell Rogers, class of 1901, of Bristol, Virginia.

Dr. John T. Moncrieff, Columbus, Georgia.

William C. Bilbro, M.D., class of 1884, Murfreesboro, Tennessee.

MARRIAGES

Dr. Frederick Strattner Orem, class of 1900, of Baltimore, Maryland, was married in the middle of January, to Mrs. Elizabeth E. Kinstendorf.

Mr. Eugene F. Cordell, Jr., son of Dr. E. F. Cordell, Sr., class of 1868, of 855 N. Eutaw street, Baltimore, Maryland, was maried at Rockville, Maryland, January 7, 1906, to Miss Martha D. Rogers, of Virginia.

Dr. Taylor Edwin Darby, Class of 1904, formerly of Maryland, but now stationed at Panama, in the service of the Panama Canal Commission, was married January 11, 1906, at Barnesville, Maryland, to Miss Helen Story, daughter of Professor and Mrs. Thomas Story, of Barnesville, Maryland.

Dr. Craig Barrow, class of 1900, a successful and prominent young physician of Savannah, Georgia, who, during his student days, was one of the most popular men of his class and captain of the football team for three years, during which period it reached its pinnacle of perfection, was married January 3, 1906, to Miss Elfrida DeRenne, also of Savannah.

DEATHS

Mrs. Anna Frances Ellis, wife of Dr. R. H. P. Ellis, class of 1877, died recently at her home, 22 N. Carey street, Baltimore, Maryland, from a complication of diseases, after a year's illness, aged 53 years.

On Tuesday, January 23, 1906, an infant daughter of Dr. Isaac Ridgeway Trimble, class of 1884, now professor of anatomy and clinical surgery, at the College of Physicians and Surgeons, Baltimore, departed this life.

Dr. William E. Hodges, a prominent physician of Howard county, died at his home, Ellicott City, January 16, 1906, in the 76th year of his age A graduate of the class of 1856, he has practiced medicine over 40 years, and was widely and favorably known throughout his community.

Dr. Alexius L. Middleton, class of 1860, aged 73, died suddenly at his home, in Piscataway District, Prince George's county, January 8, 1906. For many years Dr. Middleton practiced in the southern section of Prince George's county, Maryland, and was held in high esteem by his clientele.

Dr. William W. Robertson, class of 1864, for over 40 years a well-known physician of this city, and father of Police Surgeon J. C. Robertson, class of 1900, died suddenly, Wednesday, January 31, 1906, from a stroke of apoplexy; born at Plum Point, Calvert county, Maryland, Dr. Robertson migrated to Baltimore to pursue the course in medicine at the University of Maryland, and has since made this city his home. The doctor was 60 years old at the time of his demise, and had been enjoying good health up to the time of his death.

Arthur Stanley Wilson, class of 1907, son of Bishop Luther B. Wilson, an alumnus of our school of medicine, class of 1877, and grandson of Dr. Henry M. Wilson, class of 1850, and Dr. J. H. Turner, class of 1847, died at his home, Dukeland, Walbrook, Maryland, Thursday, January 18, 1906, in the 24th year of his age, of phthisis. Mr. Wilson was descended from a long line of distinguished physicians and gave promise of emulating their example, being a hard, earnest worker. In his death we lose a pupil who would be an honor to any institution, although of modest and unassuming manners, still possessing sufficient scholastic merit to attract the attention of his instructors. The BULLETIN extends its sympathy to his parents in the hour of their affliction.

Dr. William Clemm Poe, class of 1865, a member of the well-known Poe family of Maryland, and a relative of Edgar Allen Poe, brother of the Honorable John Prentiss Poe, formerly Attorney-General of Maryland, and for many years a member of the Law Faculty of the University of Maryland, died suddenly at his home, 130 W. Lanvale street, Baltimore, Md., January 20, 1906, of a complication of causes, in the 63d year of his age. Graduated in the class of 1865, Dr. Poe numbered among his classmates and friends the following distinguished members of the profession: Dr Isaac E. Atkinson, Dr. Maynard McPherson, Dr. George L. Robinson, Dr. William Lee, and Dr. G. Lane Taneyhill, Sr. The BULLETIN extends its sympathy to the family of the deceased in the hour of their affliction.